

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13054 MARYLAND STATE DEPARTMENT OF HEALTH
13054 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13066

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR
NORMAN	Newton	Alberstadt		X 9-2	1968	7 15	AM	7 15
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.	2c. DATE PRONONCED DEAD
MALE	White Hebrew	JULY 28, 1923	45 YRS					Month Day Year
7d. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	2d. HOUR				
PA.	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MONTGOMERY	7 - 2 - 1968 7 15 AM				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (kind of work done during most of working-life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA	Suburban			PHYSICIAN				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
MARYLAND	MONTG-BETHESDA	YES <input type="checkbox"/> NO <input type="checkbox"/>	5335 Pockshill Rd.					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
DAVID			ALBERSTADT	MINA				FOLKMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS 5-335 Pockshill					
YES		DOROTHY ALBERSTADT BETHESDA MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>and Remote</u> due to, or as a consequence of (c) <u>Coronary Artery Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 4201								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
22b. DATE SIGNED SEPT. 2, 1968								
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) BELDEN R. READ MD. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town, or County)								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9/3/68		23c. NAME OF CEMETERY OR CREMATORIAL KING DAVID MEMORIAL HILLS CHURCH		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR B. Dangler & Sons. 3801/475 S.W. WASH D.C.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 6 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

00005

LOCK

13055
13093

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13067

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Albert Hyman Alexander</i>	Middle <i></i>	Last <i></i>	2a. DATE OF DEATH Month Sept 14 1968	Day 14	Year 1968	2b. HOUR 10:30 AM					
3. SEX <i>Male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>9/4/48</i>	6. AGE (In years last birthday) YRS. - 18				IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 18	MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>									
10. CITY OR TOWN OF DEATH <i>Silver Spring Valley Cross Hosp</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i></i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i></i>			12b. KIND OF BUSINESS OR INDUSTRY <i></i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>MONT</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>882 College Pkwy #T-2</i>								
14. FATHER'S NAME First <i>Jack</i>	Middle <i>Fernert</i>	Last <i>Alexander</i>	15. MOTHER'S MAIDEN NAME First <i>Joyce</i>	Middle <i>Eileen</i>	Last <i>Rovner</i>	Address <i>As above</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7762</i>						Respiratory distress immaturity					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 hrs</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost.</i>											<i>16 hrs.</i>	
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>7735</i>												
19a. MEDICAL CERTIFICATION DATE OF OPERATION <i>7/13/55</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i></i>		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>10:30 A.M. SEPT 14 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>		21f. LOCATION Street or R.F.D. No. <i></i>		City or Town <i></i>		County <i></i>		State <i></i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 14 1968</i> to <i>Sept 14 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 14 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Edward J. Ferri</i>		DEGREE <i></i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <i></i>		22c. DATE SIGNED <i>8/16/68</i>						
22d. PHYSICIAN'S NAME (Type) <i>Edward J. Ferri</i>		22e. ADDRESS <i>11125 Rockville Pike, Rockville, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9/16/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>			23d. LOCATION (City or Town) <i>Silver Spring, Md.</i>		(County) <i></i>		(State) <i></i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler</i>		1331 Rockville Pike Rockville, Maryland					25a. REC'D BY REGISTRAR <i></i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
							DATE SEP 17 1968					

579054

17A 10-40 21-20

579054

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13068

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First <i>Jesse</i>	Middle <i></i>	Last <i>Alvarez</i>	2a. DATE OF DEATH Month <i>Sept.</i> Day <i>17</i> Year <i>1968</i>	2b. HOUR <i>12³⁰ M</i>
3. SEX <i>male</i>	4 RACE <i>white</i>	S. DATE OF BIRTH <i>6-10-95</i>	AGE (in years last birthday) <i>73 yrs.</i>	IF UNDER 1 YEAR MONTHS <i></i>	IF UNDER 24 HRS. DAYS <i></i>
7a. BIRTHPLACE (State or foreign country) <i>Spain</i>	7b. CITIZEN OF WHAT COUNTRY? <i>Cuba</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Bengal</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>4801 N. Lane</i>	Address <i>Bethesda (Md) 20802</i>
14. FATHER'S NAME First <i>Andres</i>	Middle <i></i>	Last <i>Alvarez</i>	15. MOTHER'S MAIDEN NAME First <i>Luisa</i>	Middle <i></i>	Last <i>Bengal</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give year or dates of service) <i>216-50-5647</i>	17. INFORMANT <i>Mrs Maria J. Bertram</i>	Address <i>4511 Frederick Ave</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, recent, left anterior ventricle wall, recent</u> DUE TO, OR AS A CONSEQUENCE OF <u>410.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis, severe, with thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>420.1</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>16 Sept., 1968</u> , to <u>17 Sept., 1968</u> , that (I) (we) last saw the deceased alive on <u>17 Sept., 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Ann M. Dimitroff MD</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>9/18/68</i>
22d. PHYSICIAN'S NAME (Type) <i>ANN M. DIMITROFF</i>		22e. ADDRESS <i>Kensington 11300 Woodson Ave. Apt. 102 Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE SEPT. 191968	23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN	23d. LOCATION (City or Town) SILVER SPRINGS MD.	(County) (State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS 1257 WISCONSIN BETHESDA	25a. REC'D BY REGISTRAR CHARLES JUDGE	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE SEP 23 1968

82081

82081



12



13069

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13052

1. DECEASED NAME (Type or print)			First Lillian	Middle none	Last Ashford	2a. DATE OF DEATH Month 9	Day 2	Year 68	2b. HOUR 3 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 8/31/1872			6. AGE (In years last birthday) 96 yrs.			
7a. BIRTHPLACE (State or foreign country) Wash., DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Wheaton,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nurs. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash., DC			13c. CITY OR TOWN Wash., DC			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1710 Surrey Lane, N.W.		
14. FATHER'S NAME First ? John			Middle Jost	Last	15. MOTHER'S MAIDEN NAME First ? Rebecca Terrett			Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Alice Bisselle			Address Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4409										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> BETWEEN ONSET AND DEATH 4 years.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500										
19a. DATE OF OPERATION X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from June 1964 to 9-7-1968, that (I) (we) lost saw the deceased alive on 9-7-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. H. Mish M.D.										22c. DATE SIGNED 9-7-68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS K. H. Mish, M. D.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-10-68		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery			23d. LOCATION (City or Town) Suitland, Md.			
24. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS 300 WEST ST. NE			25a. SEPARATE REGISTRATION DATE SEP 11 1968		25b. REGISTRAR'S SIGNATURE Charles George			

79051

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13070

13050

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, ^{in the funeral}, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR <i>2:30 PM</i>														
HERMA FRANCES ATKINSON						SEPTEMBER 20 1968																		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. DAYS HOURS MIN.													
FEMALE		WHITE		JUNE 20, 1860		49 YRS.																		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH																		
D.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTGOMERY																		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY															
TAKOMA PARK			WASH. SAN. + HOSP.			HOUSEWIFE			own home															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER																
MARYLAND			MONTGOMERY			YES <input type="checkbox"/> NO <input type="checkbox"/>		459 SOUTHAMPTON DR.																
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last															
					MARGUERITE WILEMAN																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		459 Southampton Dr. Silver Spring, Md.		Address																
No		577-40-3642		Alfred J. Atkinson																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">PART I. DEATH WAS CAUSED BY:</td> <td style="width: 70%; vertical-align: top;"> IMMEDIATE CAUSE (a) Respiratory Distress 431.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last). (b) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Anti-coagulation </td> <td style="width: 10%; text-align: right; vertical-align: bottom;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</td> </tr> <tr> <td></td> <td></td> <td style="text-align: right;">12 hrs</td> </tr> <tr> <td></td> <td></td> <td style="text-align: right;">14 days</td> </tr> <tr> <td></td> <td></td> <td style="text-align: right;">1 1/2 years</td> </tr> </table>													PART I. DEATH WAS CAUSED BY:	IMMEDIATE CAUSE (a) Respiratory Distress 431.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last). (b) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Anti-coagulation	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			12 hrs			14 days			1 1/2 years
PART I. DEATH WAS CAUSED BY:	IMMEDIATE CAUSE (a) Respiratory Distress 431.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last). (b) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Anti-coagulation	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																						
		12 hrs																						
		14 days																						
		1 1/2 years																						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 331X Coronary artery disease Diabetes mellitus																								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																
						YES <input type="checkbox"/> NO <input type="checkbox"/>																		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State														
22a. I certify that (I) (this hospital) attended the deceased from 9-5, 1968, to 9-20, 1968, that (I) (we) last saw the deceased alive on 9-20 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE		John L. Ford MD		22c. DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		DATE SIGNED												
22d. PHYSICIAN'S NAME (Type)		JOHN L. FORD MD		22e. ADDRESS		831 UNIVERSITY BLVD E SILVER SPRING, MD																		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town)		(County)		(State)														
Burial		Sept. 24, 1968		Cedar Hill Cemetery		Suitland, Maryland																		
24. FUNERAL DIRECTOR		C. Glen Carter		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																
				8434 Georgia Ave.				Charles Judge																
						DATE		SEP 25 1968																

8006



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13059

13071

1. DECEASED NAME (Type or Print)		First WALTER	Middle NMI	Last Bailey Jr.	2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/>	Month 9/ 19	Day 168	Year 10:10	2b. HOUR A
3. SEX Male	4. RACE White	5. DATE OF BIRTH 10/6/21	6. AGE (in years last birthday) 46 yrs	F UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD Month Sept 19	2d. HOUR 10:10
7a. BIRTHPLACE (State or foreign country) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. U.S.A. OCCUPATION (Kind of work done during month of working, i.e., even if retired.) Patient Searcher		12b. KIND OF BUSINESS OR INDUSTRY Self-employed			
13a. USUAL RESIDENCE (Where deceased lived, if admiss.on STATE Maryland)		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil.Sprg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2021 Lanier Dr. SSMd.	
14. FATHER'S NAME First Walter		Middle NMI	Last Bailey Sr.	15. MOTHER'S MAIDEN NAME First Lillian		Middle ?	Last Haynes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 577-20-0873		17. INFORMANT wife Carol P.		ADDRESS 2021 Lanier Dr. SSMd.			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).</p> <p>PART I. DEATH WAS CAUSED BY</p> <p>41-7</p> <p>IMMEDIATE CAUSE (a) Myocardial Infarction, acute DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>(b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden - Years.</p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>TAB</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>									
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Sept. 20, 1968	
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		23b. DATE 9-23-68		23c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		23d. LOCATION (City or Town) Rockville Montg. Maryland		(County) (State)	
24. FUNERAL DIRECTOR M. Andrew Dwane		ADDRESS Warren E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.		25a. REC'D BY REGISTRAR SEP 25 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

400

CERTIFICATE OF DEATH

13072

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. In any event, within 72 hours after death, this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First MARY	Middle Blanche	Last BALDWIN	2a. DATE OF DEATH Month SEPT Day 14 Year 1968	2b. HOUR 5:55 AM
3. SEX Female	4. RACE white	5. DATE OF BIRTH Dec 3, 1884		6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Indiana	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY	
8 WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>				
10. CITY OR TOWN OF DEATH Rockville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nurs Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Part-time
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY MONTGOM. Rockville	13c. CITY OR TOWN Rockville	13d. INS DE CITY LIMITS? YES	13e. STREET AND NUMBER 12908 Turkey Br.	
14. FATHER'S NAME First William	Middle Vestal	Lost	15. MOTHER'S MAIDEN NAME First Middle Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO 313-54-1954	17. INFORMANT Mrs. J. A. Milligan	Address same as item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369 Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Arteriosclerosis last 331X (b) Due to, or as a consequence of (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a) ① Fracture of hip ③ pulmonary embolism					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from August 1968 to September 1968 , that (I) (we) last saw the deceased alive on 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Barton Gershon, M.D.	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 9/4/68		
22d. PHYSICIAN'S NAME (Type) Barton Gershon	22e. ADDRESS 50 W. Edmonston Street Rockville, Maryland				
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial	23b. DATE 9-17-68	23c. NAME OF CEMETERY OR CREMATORIAL North Star Cemetery	23d. LOCATION (City or Town) Mt. Airy., Indiana	(County) Indiana	(State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland	ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland	25a. REC'D BY REGISTRAR DATE SEP 18 1968	25b. REG STRR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13061

CERTIFICATE OF DEATH

13073

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First Joseph	Middle nnn	Barnabas Baranello	2d. DATE OF DEATH Month Sept	Year 68	2d. HOUR 10:20A.M.		
3. SEX		4 RACE Male	White	S. DATE OF BIRTH 10-7-79	6. AGE (in years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? Italy	U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash Sah & Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) painter (Mural) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8642 Piney Br Rd				
14. FATHER'S NAME First Unknown		Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 186-09-8005		17. INFORMANT Louis J. Baranello	Address Silver Spring 8642 Piney Br. Rd				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Infarction							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 4104		DUE TO, OR AS A CONSEQUENCE OF Generalized Arteriosclerosis , 3-5 minutes							
(b)									
DUE TO, OR AS A CONSEQUENCE OF 4201									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Insgtive Heart Failure Chronic Brain Syndrome)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (we) attended the deceased from Jan 1964 to Sept 29, 1968 , that (I) (we) last saw the deceased alive on Sept 29, 1968 ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Alan R. Gair MD		DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9/29/68				
22d. PHYSICIAN'S NAME (Type) Alan R. Gair MD		22e. ADDRESS 3118 Craiglawn Rd, Beltsville, Md							
23a. BURIAL, CREMATION, REMOVAL'S Removal		23b. DATE 9/30/68	23c. NAME OF CEMETERY OR CREMATORIAL Westminster Cemetery		23d. LOCATION (City or Town) Montgomery Co.; Pa.	(County)	(State)		
24. FUNERAL DIRECTOR The S.H. Hines Co.		ADDRESS 2901-14th Street N.W. Washington, D.C.	25a. REC'D BY REGISTRAR DATE OCT 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

2010-00000

2010-00000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers [box 1] and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1306 13062		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH				13074			
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. H.M.		
Frances		Annabella		Barker	Month	Day	Year		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday) 41 YRS			
Female		White		16 May 1927		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0			
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. US JAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13c. CITY OR TOWN Montgomery		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9918 Old Spring Road			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
		Aleck		Carter			Kathleen		Lipe
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO. 579-30-4476		17. INFORMANT Bethesda, Maryland		Address The Medical Records, The Clinical Center			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Sepsis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 - 4 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF Lymphosarcoma				1 year			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3 September 1968, to 6 Sept. 1968, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 6 September 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE <i>Michael B. Mosher, MD</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) Michael B. Mosher, M. D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 10, 1968		23c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		23d. LOCATION (City or Town) Rockville, (County) (State) Md.			
24. FUNERAL DIRECTOR JOSEPH GAWLER SONS, INC.		ADDRESS 5130 Wisconsin Ave., Washington, D.C.		25a. REC'D BY REGISTRAR DAT SEP 13 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1984

13063

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

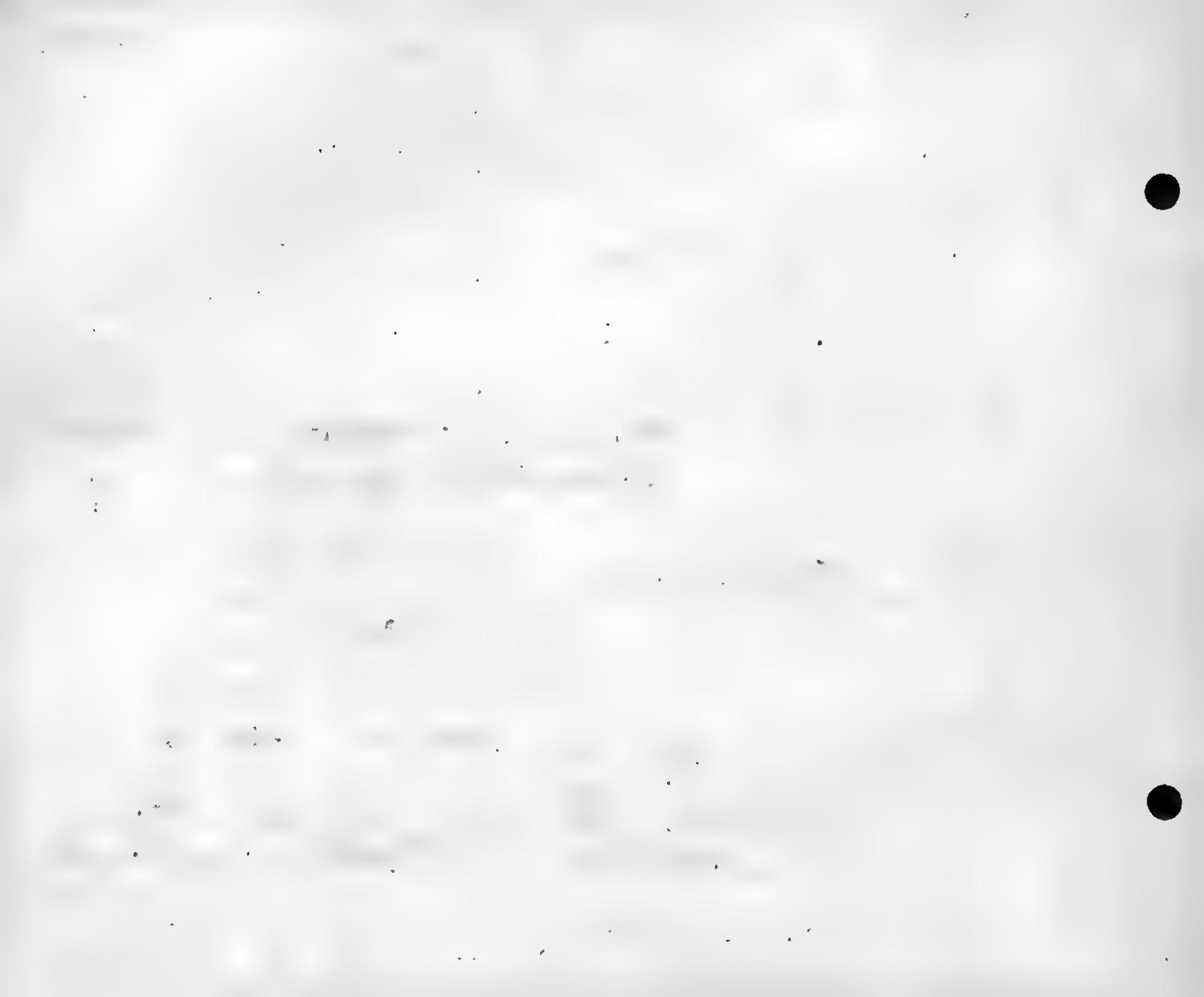
CERTIFICATE OF DEATH

13075

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Agnes</i>	Middle <i>Stewart</i>	Last <i>Beall</i>	2a. DATE OF DEATH Month <i>Sept</i>	Day <i>10</i>	Year <i>1968</i>	2b. HOUR <i>3:30 PM</i>
3. SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>Sept. 2 - 1882</i>			6 AGE (in years last birthday) <i>86 yrs.</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>				
10. CITY OR TOWN OF DEATH <i>Oney</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Brooke Grove Foundation</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>School Teacher</i>			12b KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>	13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Washington</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>3130 Oliver St. N.W.</i>			
14 FATHER'S NAME First <i>Alexander</i>	Middle <i>Stewart</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Josephine</i>	Middle	Last <i>Plant</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>John Beall</i>	17 INFORMANT <i>John Beall</i>	Address <i>5704 Hazel Lane - McLean, Va.</i>			APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH <i>24 hrs</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>44</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>After atherosclerosis generalized</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>4 yrs</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>5 cm transverse</i>							
19a. DATE OF OPERATION <i>4500</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>Office building, etc.</i>		21f. LOCATION Street or R.F.D. No. <i>5130</i>	City or Town <i>61</i>	County <i>9</i>	State <i>10 1968</i>
22a. I certify that (I) (his hospital) attended the deceased from saw the deceased alive on <i>9/10 1968</i> , and that in my (my) (or) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did) (did) view the body after death.							
22b. SIGNATURE <i>C.H. Johnson MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9/11/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>C.H. Johnson MD</i>		22e. ADDRESS <i>Sandy Spring, Md 20880</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9/13/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Glenwood Cemetery</i>			23d. LOCATION (City or Town) <i>Washington, D.C.</i>	(County) (State)
24. FUNERAL DIRECTOR <i>The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>SEP 13 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

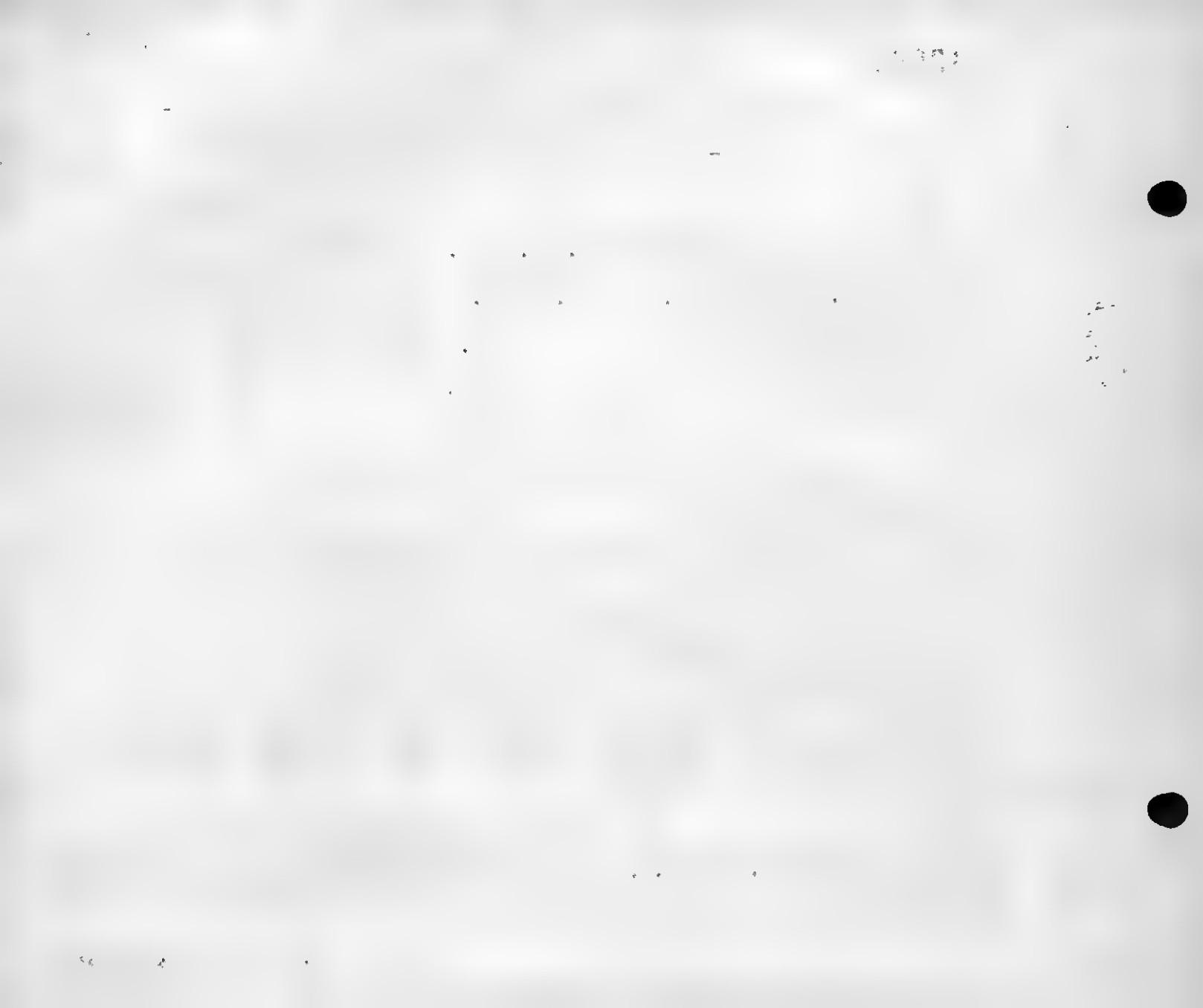
Items 18&22a Film 404 MARYLAND STATE DEPARTMENT OF HEALTH
9-25-68 a.m. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13076

13064

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED				Month	Day	Year	2b. HOUR
SHARON ESTHER BEGUN						9-9-	168	M					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday) — YRS.	7 IF UNDER MONTHS	YEAR DAYS	8 IF UNDER 24 HRS HOURS	MIN		2c. DATE PRONOUNCED DEAD				2d. HOUR
Female	White	7-19-68		1	21				Month	9	Day	19 68	7:50pm
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		Montgomery				Md.	
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR (INDUSTRY)				
Takoma Park			Wash. San. & Hosp.			None							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER				
Md.			P.G.			W.Hyatts.,			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2401 Sheridan St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
Eugene Begun						A. Dorcia Finklestein							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			None			Parents							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Viral pneumonitis, acute													hrs.
480 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
490 X													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													22b. DATE SIGNED
Belden R. Reap M.D.													9/9/1968
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M.D.		23d. LOCATION (City or town) (County) (State)			
Belden R. Reap													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or town) (County) (State)							
Burial		9-11-68		NATH MEMORIAL PARK		FALLS CHURCH							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Goldcoff Funeral Home 4217 9th St. N.W.				DATE SEP 16 1968		Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13065

13077

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove correct copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 2 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Lost	2a DATE OF DEATH Month 9	Day 4	Year 68	2b. HOUR 8 P M
Esther (no middle name) Beram							
3. SEX Female	4 RACE Caucasian	5. DATE OF BIRTH 2/12/1888			6. AGE (In years last birthday) 80	IF UNDER YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Rumania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			Md	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY J.M.T.P? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 513 University Blvd.		
14. FATHER'S NAME Lippa Hersh (middle name unknown)	First	Middle	Lost	15. MOTHER'S MAIDEN NAME Unknown	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 213-54-6506	17. INFORMANT Garlick Funeral Home, Bronx, N.Y.	Address				
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiovascular collapse</i> 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic Adenocarcinoma of Stomach</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <i>1519 Pericarditis</i> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-7 days 6-8 mo.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1519 Pericarditis</i>							
19a. DATE OF OPERATION Apr 68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ca of Stomach	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that () (this hospital) attended the deceased from <i>April, 1968</i> , to <i>9/4, 1968</i> , that (I) (we) last saw the deceased alive on <i>9/4, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Jerome H. Epstein</i>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>9/4/68</i>			
22d. PHYSICIAN'S NAME (Type) Jerome Epstein, M. D.	22e. ADDRESS <i>214-RST 2021 1st St., NW, Washington, DC</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-6-1968	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hebron Cemetery	23d. LOCATION (City or Town) Flushing	(County) N. Y.	(State)		
24. FUNERAL DIRECTOR Gowens Funeral Home 4217 9th Street	ADDRESS NW	25a. REC'D BY REGISTRAR DATE SEP 6 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13066

13078

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician
or director, page 3 should be detached for use as the burial permit. Then please remove carbon papers and file
with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.*Cleared with Medical Examiner J. Bell*

1. DECEASED NAME (Type or print)	First <i>John</i>	Middle <i>A</i>	Last <i>Berkey</i>	2a. DATE OF DEATH Month <i>Sept.</i>	Day <i>24</i>	Year <i>1968</i>	11:30			
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>July 23, 1887</i>			6. AGE (In years last birthday) <i>81</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	IF UNDER 24 M.S. M.N. <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery</i>							
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington San & Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Carpenter</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Mining Company</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spgs.</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>104 Park Valley Estates Road</i>						
14. FATHER'S NAME First <i>Amos</i>	Middle <i>Berkey</i>	Last <i>Eliza</i>				Middle <i>Millie</i>	Last <i>Hawley</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>190-05-3375</i>	17. INFORMANT <i>Margaret Weaver 104 Park Valley Road</i>				Address <i>Sil. Spr. Md.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute peritonitis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Peptic ulcers, (2), with perforation of</i> DUE TO, OR AS A CONSEQUENCE OF <i>1 into greater abdominal</i> (c) <i>cavity.</i>									5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Generalized arteriosclerosis.</i>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes.</i>					
MEDICAL CERTIFICATION 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 22, 1968</i> , to <i>Sept. 24, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept. 23, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (not) view the body after death.									22c. DATE SIGNED <i>Sept. 24, 1968</i>	
22b. SIGNATURE <i>Harold S. Tidler, M.D.</i>		DEGREE <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.								
22d. PHYSICIAN'S NAME (Type) <i>Harold S. Tidler, M.D.</i>		22e. ADDRESS <i>9801 Georgia Ave., Sil. Sp., Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9-27-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Richland Cemetery</i>	23d. LOCATION (City or Town) <i>Geistown</i>	(County) <i>Penna.</i>	(State)					
24. FUNERAL DIRECTOR <i>WLee</i>	ADDRESS <i>Warren E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.</i>	25a. REC'D BY REGISTRAR DATE <i>SEP 27 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #15 Film G 418 31/6/68 ab

1306?

CERTIFICATE OF DEATH

13079

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First ANDREA	Middle J.	Last BERTORELLI	20. DATE OF DEATH Month 9 Day 14 Year 1968	26. HOUR 11:50 P.M.			
3. SEX Male	4. RACE White	S. DATE OF BIRTH 14-11-1895	6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN				
7a. BIRTHPLACE (State or foreign country) Italy	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOTEL COOK	12b. KIND OF BUSINESS OR INDUSTRY Food					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5410 14th Place					
14. FATHER'S NAME First LOUGI	Middle BERTORELLI	15. MOTHER'S MAIDEN NAME First UNNICKX/11	Middle Marie Resteghini Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No	16b. SOCIAL SECURITY NO. 578 01 04821	17. INFORMANT IDA BRUGNOLI Address 1401 QUEBEC ST. HEATHSVILLE, VA						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST, CO ₂ NARCOSIS, RESP. ACIDOSIS DUE TO, OR AS A CONSEQUENCE OF (b) EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c) ASTHMA								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS +20 YEARS +50 YEARS								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)								
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
		22a. I certify that (I) (this hospital) attended the deceased from 2/15/68, 1968, to 9/14/68, 1968, that (I) (we) last saw the deceased alive on 9/14/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (he) (she) (did not) view the body after death.						
		22b. SIGNATURE Henry R. Wolfe	DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9/15/68	
		22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-18-68	23c. NAME OF CEMETERY OR CREMATORIAL MT OLIVET CEM.	23d. LOCATION (City or Town) WASH. D.C.	(County)	(State)		
24. FUNERAL DIRECTOR W. W. CHAMBERS CO.		ADDRESS 1401 CHAMBERS ST. WASH. D.C.	25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
			DATE SEP 17 1968					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

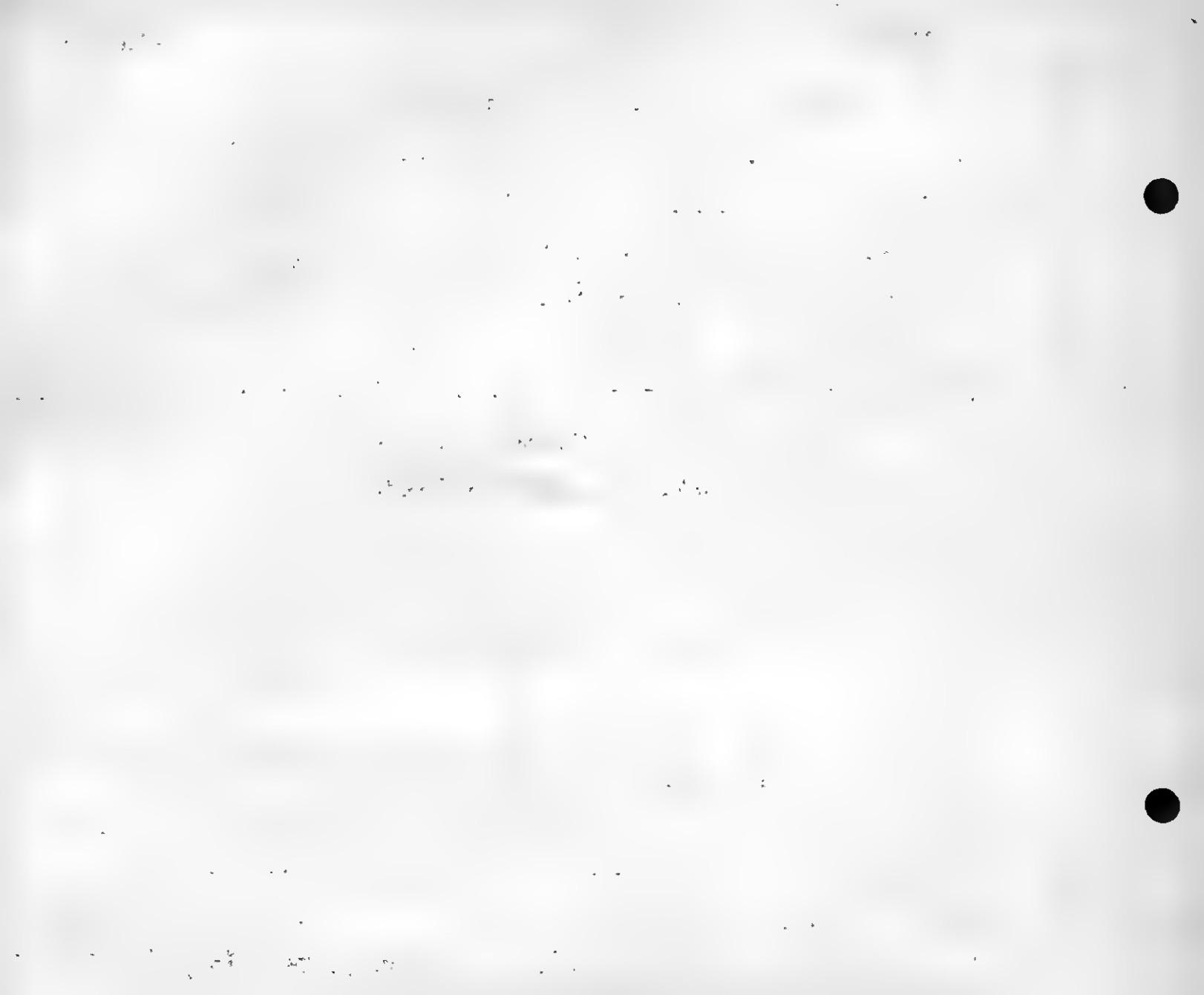
13068

13080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Bertha</i>	Middle <i>C.</i>	Lost <i>- BX</i>	2a. DATE OF DEATH Month <i>Sept</i>	Doy <i>21</i>	Year <i>1968</i>	2b. HOUR <i>11AM</i>				
3. SEX <i>Female</i>		4 RACE <i>White</i>	5. DATE OF BIRTH <i>April 24, 1880</i>		6. AGE (In years lost birthday) <i>88 yrs.</i>			IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Michigan</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>					
10 CITY OR TOWN OF DEATH <i>Silver Spring,</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>305 Ellsworth Drive</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>House wife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>				
13a. J.S.J.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Sil. Spring</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	13e. STREET AND NUMBER <i>305 Ellsworth Drive</i>						
14. FATHER'S NAME First <i>Frederick</i>		Middle <i>Laubengayer</i>	Lost <i></i>	15. MOTHER'S MAIDEN NAME First <i>Caroline</i>		Middle <i></i>	Lost <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-48-5188</i>	17 INFORMANT <i>Mrs. J. Paul Blaess</i>	Address <i>305 Ellsworth Drive S.S.</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) <i>arteriosclerotic cardio</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>vascular disease</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i>												
19a. DATE OF OPERATION <i>4/22/68</i>		19b. CONDIT. ON FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Doy Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <i>June</i> , 19 <i>60</i> , to <i>21 Sept</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>21 Sept</i> , 19 <i>68</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> view the body after death.												
22b. SIGNATURE <i>Ernest E. Harmon M.D.</i>		22c. DATE SIGNED <i>21 Sept. 1968</i>		22d. PHYSICIAN'S NAME (Type) <i>Ernest E. Harmon M.D.</i>		22e. ADDRESS <i>9301 Colesville Rd. Sil. Spq. Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Sept. 24, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Bethlehem Cemetery</i>		23d. LOCATION (City or Town) <i>Ann Arbor</i>		(County) <i>Michigan</i>		(State)		
24 FUNERAL DIRECTOR M. Andrew Duvall Warner E. Pumphrey Inc.		ADDRESS <i>8434 Ga. Ave. S.S. Md.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 25 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

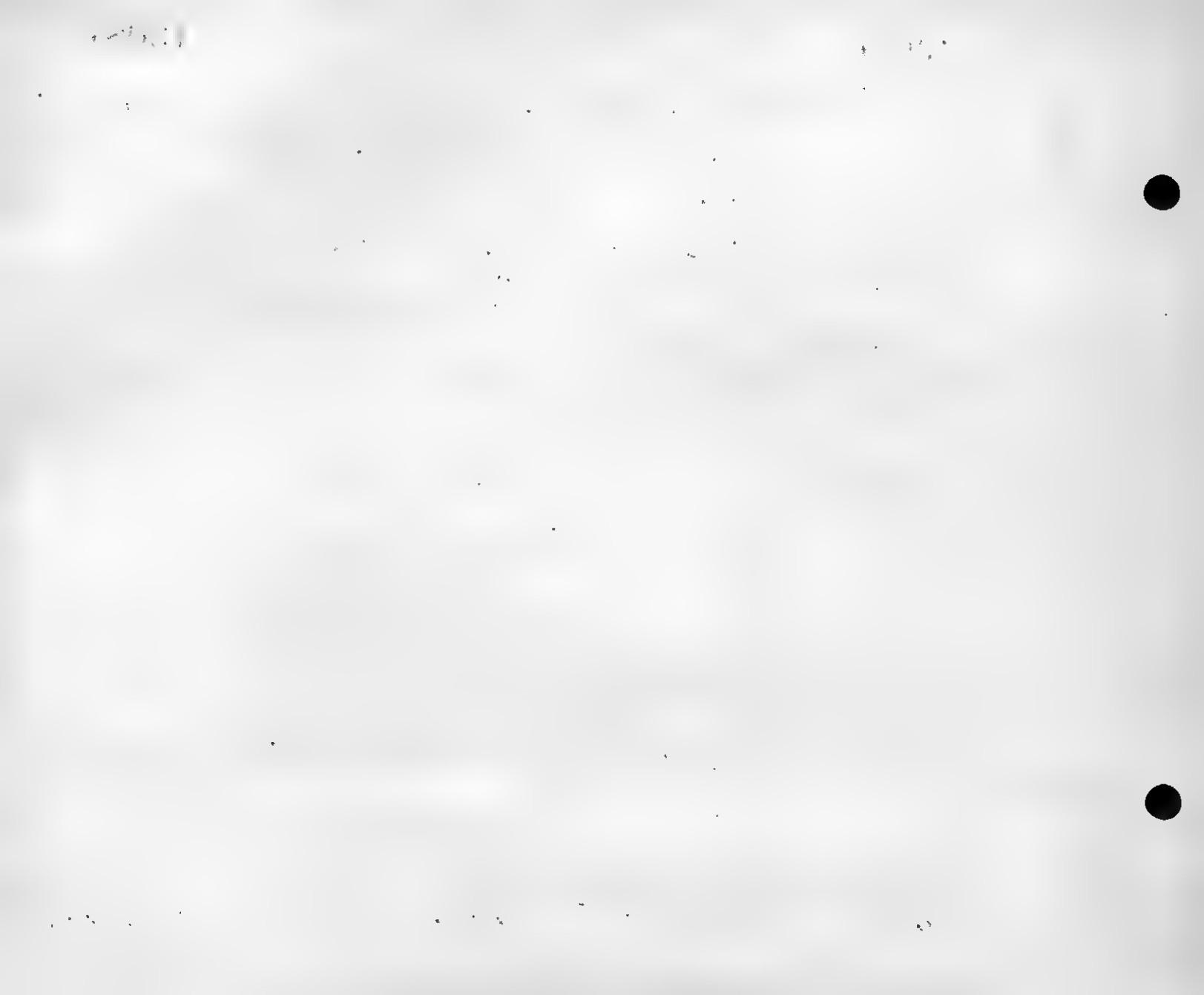
CERTIFICATE OF DEATH

13069

13081

Please enter coroner or physician.
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First SARA	Middle NMN	Last Bloom	2a. DATE OF DEATH Month 9		Year 68	2b. HOUR 10 00 M	
3. SEX F		4 RACE W	5. DATE OF BIRTH 4-17-82		6. AGE (in years last birthday) 86 yrs.		IF UNDER 1 YEAR MONTHS 86		
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? Amer.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery		12b. KIND OF BUSINESS OR INDUSTRY Housewife		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanatorium			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Resided before admission) STATE Md.		13c. CITY OR TOWN Montgomery Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11200 Lockwood Drive				
14. FATHER'S NAME Moses		Middle DARROW	15. MOTHER'S MAIDEN NAME Ida						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO.	17. INFORMANT Patient's chart		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urema		DUE TO, OR AS A CONSEQUENCE OF Renal failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 403 X		DUE TO, OR AS A CONSEQUENCE OF Neoplasclerosis.		2 weeks					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 775									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from August 19, 1968 , to Sept 4, 1968 , that (I) (we) last saw the deceased alive on Sept 4, 1968 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Arthur S. Bresler M.D.		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS.			22c. DATE SIGNED Sept 4, 1968	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-5-68	23c. NAME OF CEMETERY OR CREMATORIAL Levitt Israel		23d. LOCATION (City or Town) Harrisburg-Poughkeepsie, N.Y.		(County) Harrisburg-Poughkeepsie, N.Y.		(State)
24. FUNERAL DIRECTOR W.W. Chamber Co		ADDRESS 1400 Chapman St. N.Y.		25a. REC'D. BY REGISTRAR SEP 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13070

13082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Please send 2 direct to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First PAULINE	Middle S.	Last BOHLER	2a. DATE OF DEATH Month SEPTEMBER Year 1968 Day 8	2b. HOUR 3:30 P.M.
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH FEB. 23, 1893	6. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) GERMANY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE NEW JERSEY	13b. COUNTY Monmouth	13c. CITY OR TOWN W. BELMAR	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1102 CURTIS AVENUE	
14. FATHER'S NAME First Herman	Middle Eberle	15. MOTHER'S MAIDEN NAME First Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <input checked="" type="checkbox"/>	16b. SOCIAL SECURITY NO. _____	17. INFORMANT Oscar A. Behler	17705 Address Tree Lawn Dr. Ashton Md. 20702	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 41- CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. 44-5x DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) DIABETES MELLITUS					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. _____	City or Town _____	County _____	State _____
22a. I certify that (I) (this hospital) attended the deceased from 9/8/68 to 9/8/68, that (I) (we) last saw the deceased alive on 9/8/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE DAVID GOLDENBERG	ATTENDING DEGREE MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9/8/68		
22d. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG	22e. ADDRESS 9801 GEORGIA SILVER SPRING MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Sept. 9 1968	23c. NAME OF CEMETERY OR CREMATORIAL MERRIMOUTH MEMORIAL	23d. LOCATION (City or Town) Neptune	(County) New Jersey	(State)
24. FUNERAL DIRECTOR Francis H. Barber	ADDRESS Laytensville, Md.	25a. REC'D BY REGISTRAR DATE SEP 10 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

• 10 JUN 1968

→ 17

四

• 2 - 11 - 7

2

卷之三

— 1 —

T. T. T. 2

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

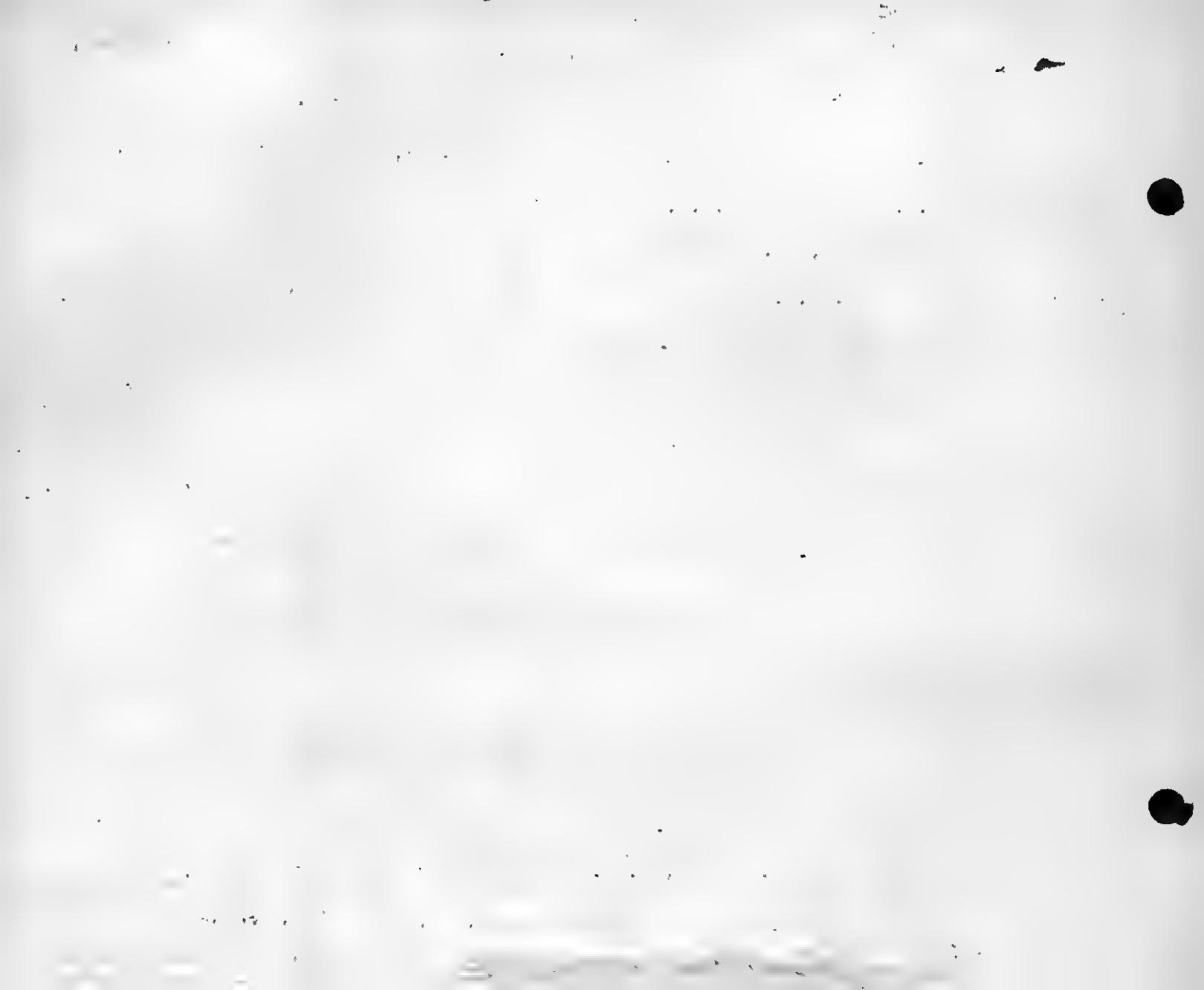
13072

13083

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Wendell</i>	Middle <i>C.</i>	Last <i>Boone</i>	2a. DATE OF DEATH Sept. Month Doy 26 Year 68	2b. HOUR 11:30 AM
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH Sept. 27, 1896		6. AGE (In years lost, birthday) 71 YRS.	7. IF UNDER 1 YEAR MONTHS 11 DAYS 24 HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>N.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Takoma Park, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Sanitarium</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Wash. D.C.</i>		13c. CITY OR TOWN <i>12b. COUNTY</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>521 12th Street, N. E.</i>	
14. FATHER'S NAME First <i>John</i>	Middle <i>Boone</i>	15. MOTHER'S MAIDEN NAME First <i>Clara</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis Liver</i> DUE TO, OR AS A CONSEQUENCE OF <i>unknown</i> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <i>anemia</i> DUE TO, OR AS A CONSEQUENCE OF <i>unknown</i> lost. (c) <i>Primary unknown</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1978</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1978</i>					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Doy Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 13, 1968</i> , to <i>Sept 26, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 26, 1968</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Henry G. Hadley</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Sept 27 68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Henry G. Hadley, M. D.</i>		22e. ADDRESS <i>601 Nekul Ave 541/28</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE 10-2-68	23c. NAME OF CEMETERY OR CREMATORIALY <i>Harmony Memorial Park</i>	23d. LOCATION (City or Town) <i>Prince George, Md.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Rheem Funeral Home - 3015-1215 F.Y.E.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>OCT 2 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



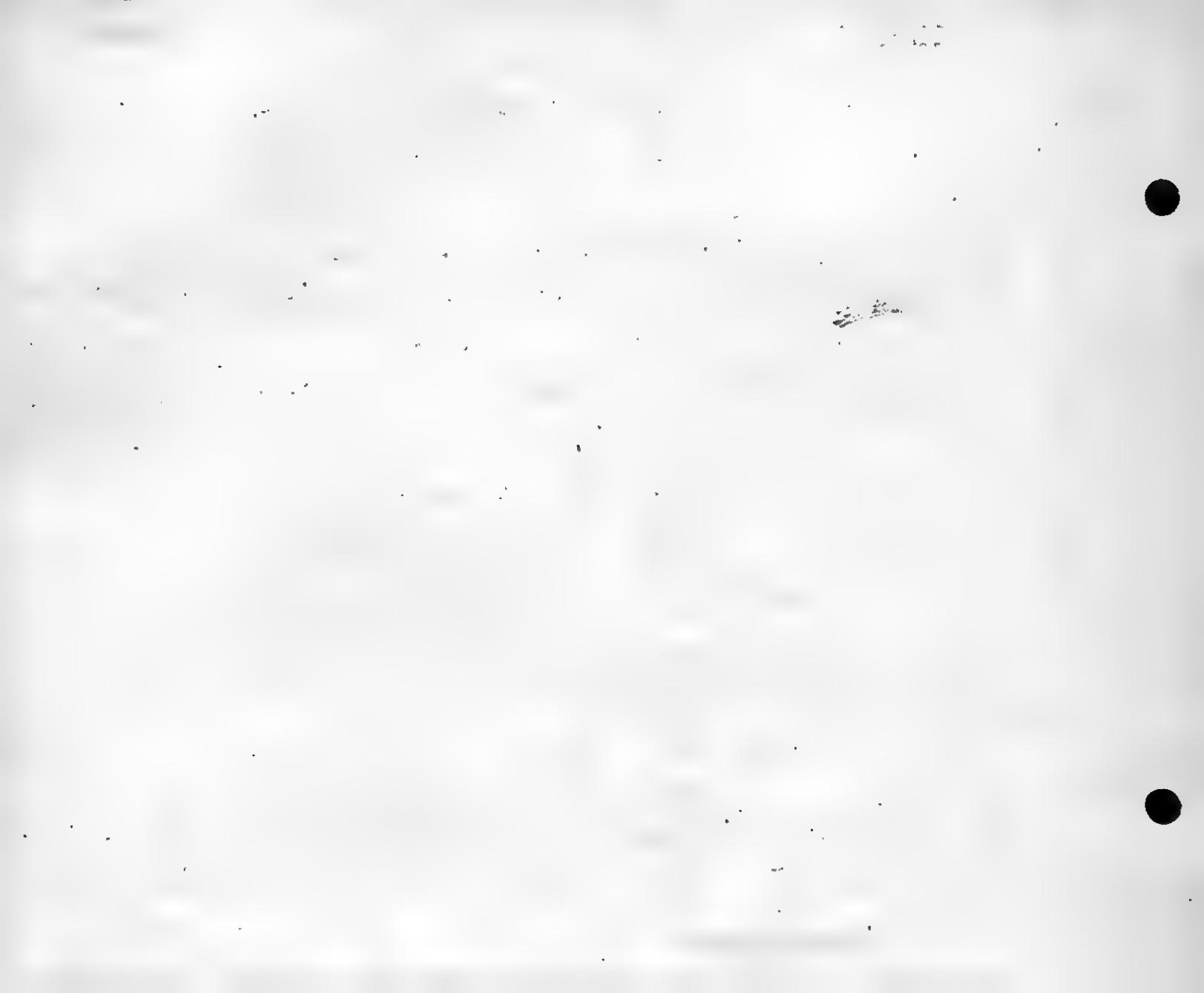
MARYLAND STATE DEPARTMENT OF HEALTH

13072 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 130 & 13e, Film G405 10/8/68 jp CERTIFICATE OF DEATH

13084

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages one and two should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First KATE	Middle S.	Last BORNSTEIN	2a. DATE OF DEATH Month Sept. 30 Year 1968	2b. HOUR 6 P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH Jan. 10, 1892		6. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Austria	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa Convalescent		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13c. CITY OR TOWN Montgomery	13d. INSIDE CTY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1950 14th Ave.	13f. ADDRESS Woodmoor Ave Bethesda, Md.	
14. FATHER'S NAME F Nathan	Middle Smith	15. MOTHER'S MAIDEN NAME Rebecca	16. ADDRESS Hausworth		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO.	17. INFORMANT Alfred Bornstein, Son, 7711 Woodmoor Ave Bethesda, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 30 min.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. V. A. DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic heart disease					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (not hospital) attended the deceased from Oct. 1, 1967, to Sept. 30, 1968, that (I) (we) last saw the deceased alive on Sept. 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Aaron H. Traum		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED Sept. 30, 1968.
22d. PHYSICIAN'S NAME (Type)	A. Traum	22e. ADDRESS 8237 Georgia Avenue, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/3/68	23c. NAME OF CEMETERY OR CREMATORIAL Lakeside Memorial Park	23d. LOCATION (City or Town) Miami Beach, Fla.	(County)	(State)
24. FUNERAL DIRECTOR B. Darz. & Sons	ADDRESS 3501 14th St. N.Y.	25a. REC'D BY REGISTRAR OCT 3 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

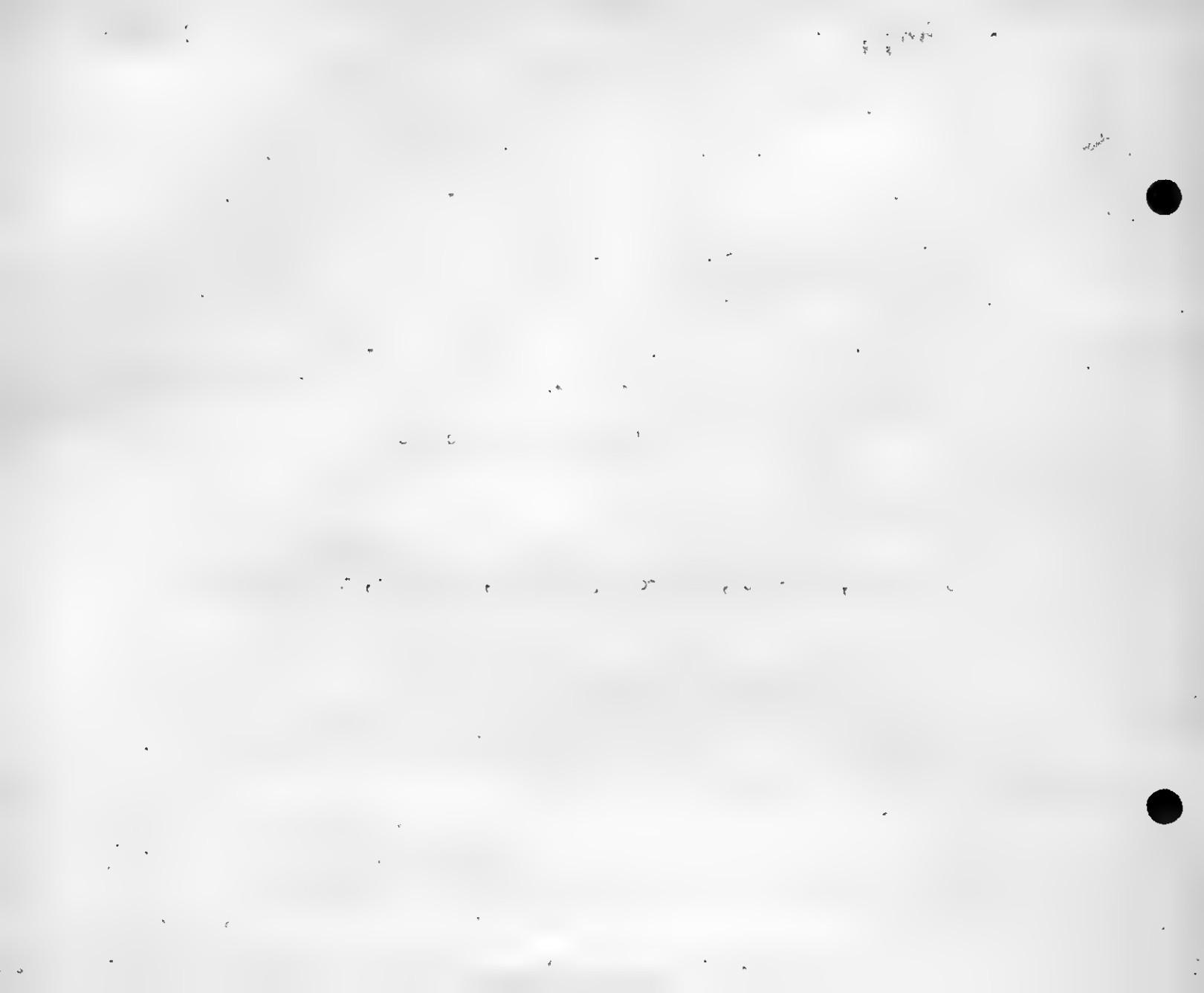
13073

13085

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
PAGE 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, **PAGE 3** should be detached for use as the burial-transit permit. Then please remove carbon papers. **PAGES 1 and 2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>JOSEPH</i>	Middle <i>H</i>	Last <i>Boyle</i>	2a. DATE OF DEATH Month <i>Sept</i>	Day <i>6</i>	Year <i>1968</i>	2b. HOUR <i>2 P.M.</i>
3. SEX <i>Male</i>	4 RACE <i>white</i>	5. DATE OF BIRTH <i>12/28/86</i>		6. AGE (in years last birthday) <i>81</i>		IF UNDER 1 YEAR MONTHS <i>YRS</i>	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Silver Spring Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Rockville</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>McQueeney</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>245 Rollins Ave. Apt. T.3</i>			
14. FATHER'S NAME First <i>Cornelius</i>	Middle <i>Boyle</i>	Last <i>Kate</i>	15. MOTHER'S MAIDEN NAME First <i>McQueeney</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>882-28-8029</i>	17. INFORMANT <i>Joseph C. Boyle</i>	Address <i>Son - 307 Silver Blv. Rockville, MD</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary insufficiency</i>							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause last. <i>4/20/61</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Carcinoma, prostate, gastro-jejunostomy, anterior, post 3 years</i>							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/15/66</i> , to <i>9/5/68</i> , that (I) (we) last saw the deceased alive on <i>9/5/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>DR LEO J DONOVAN</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9/6/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>DR LEO J DONOVAN</i>		22e. ADDRESS <i>8218 WISCONSIN AVN BROOKLYN, NY</i>					
23a. BURIAL, CREMATION, <input checked="" type="checkbox"/> BURIAL <input type="checkbox"/> CREMATION	23b. DATE <i>9/10/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Cross Cemetery</i>	23d. LOCATION (City or Town) <i>Brooklyn</i>	(County) <i>New York</i>	(State)		
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>	ADDRESS <i>1331 Rock. Pike</i>	25a. REC'D BY REGISTRAR <i>SEP 9 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13086

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
<i>Alice Lee Bradford</i>				<i>Sept 14 1968</i>	<i>8:18 A.M.</i>
3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
<i>Female</i>	<i>Caucasian</i>	<i>11/3/85</i>	<i>82</i>		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
<i>Md.</i>	<i>U.S.</i>		<i>Montgomery</i>		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION ((If not in hospital give street address))	12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
<i>Wheaton</i>	<i>Randolph Hills Nursing Home</i>	<i>part-time</i>	<i>Montgomery</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
<i>Md.</i>	<i>Montgomery</i>	<i>Rockville</i>	<i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	<i>4713 Tallchance Ave</i>	
14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last				
<i>George</i>	<i>Gatherer</i>	<i>Ollie</i>	<i>Delores</i>	<i>L.</i>	<i>Layton</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address <i>Rockville, Md.</i>		
<i>No</i>	<i>577-14-1004</i>	<i>Mrs. Madora Delores 4713 Tallchance Ave.</i>			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 years.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Edema carcinoma of uterus</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arterosclerotic heart disease & cerebral infarction</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Town</i> , 19 <i>67</i> , to <i>Sept 14, 1968</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>Sept 12, 1968</i> , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.					
22b. SIGNATURE <i>Michael R. Dobridge</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Sept 14 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>Michael R. Dobridge, M.D.</i>	22e. ADDRESS <i>9801 George Ave., Silver Spring, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>9-17-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lincoln Cemetery</i>	23d. LOCATION (City or Town) <i>Prince George's, Md.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>J. W. Lee</i>	ADDRESS <i>Maryland</i>	25a. REC'D BY REGISTRAR <i>SEP 18 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

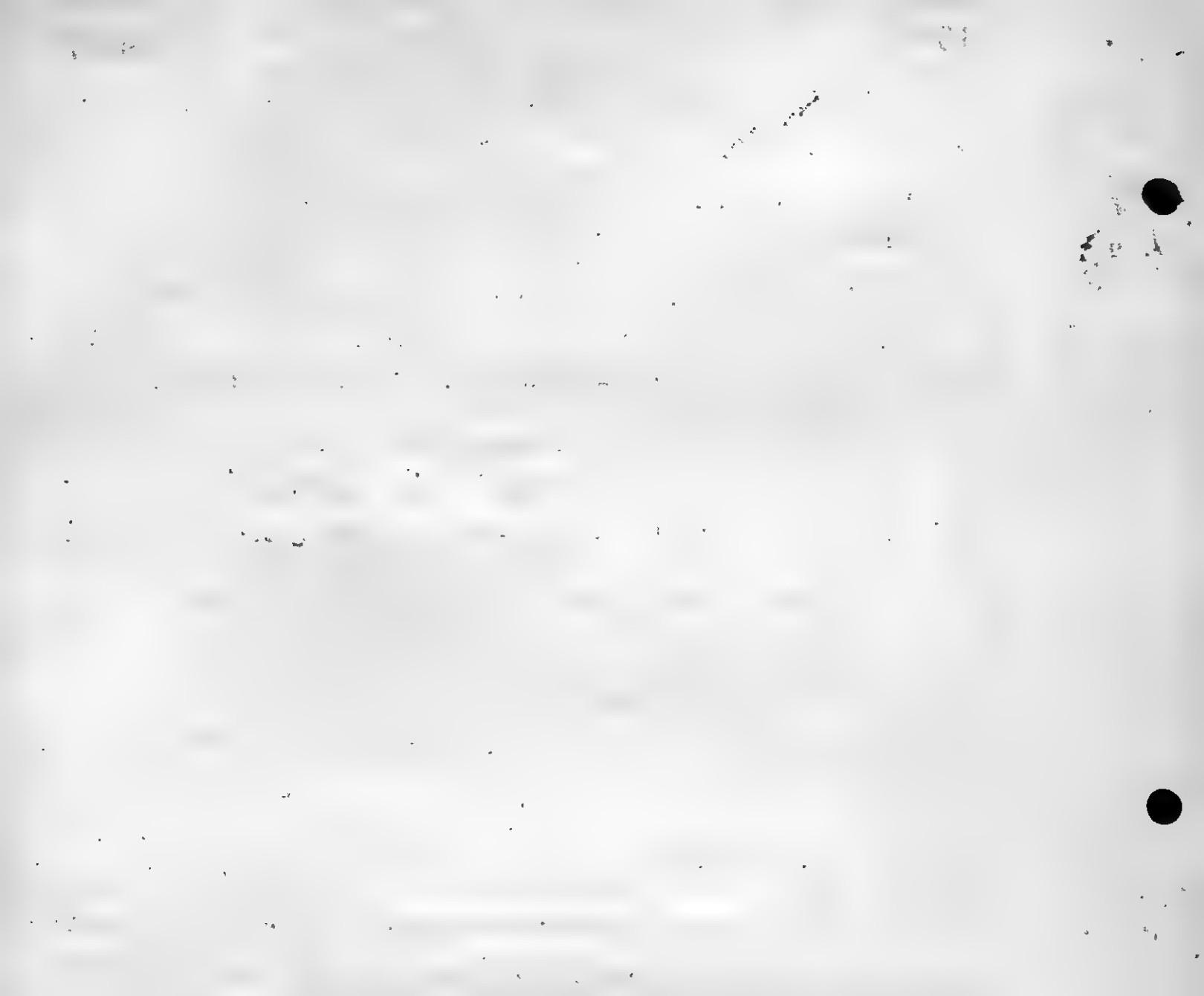
CERTIFICATE OF DEATH

13075

13087

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First CLEYTA	Middle BELLE	Last BRADFORD	2a. DATE OF DEATH Sept 7 1968	Month Year 1968	Day 11	2b. HOUR AM	
3. SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH 11/28/13		6. AGE (In years last birthday) 54		F UNDER 1 YEAR YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY				
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.	13b. COUNTY MONT.	13c. CITY OR TOWN BETHESDA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4926 BATTERY LANE				
14. FATHER'S NAME Robert	First Middle JONES	15. MOTHER'S MAIDEN NAME First George	Middle Last		Address Rockville			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown)	16b. SOCIAL SECURITY NO None	17. INFORMANT 577-01-0594 SON (MR. ALTON BRADFORD)			Approximate Interval Between Onset and Death 1 hr			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) <u>Metastatic Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gland-Carcinoma of Pancreas</u> last 3 mo								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19c. MEDICAL CERTIFICATION 151X		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>August 1963</u> , to <u>9/7 1968</u> , that (I) (we) last saw the deceased alive on <u>9/6 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Frank G. Jaggers Jr. M.D.</u>	22c. DATE SIGNED 9/7/68	ATTENDING PHYS <input checked="" type="checkbox"/> AGREE	DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (Type) FRANK JAGGERS	22e. ADDRESS 5707 Wisconsin Ave.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept 10 1968	23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial	23d. LOCATION (City or Town) Cambridge Dorchester Md	(County)	(State)			
24. FUNERAL DIRECTOR Robert A Pumphrey	ADDRESS 3557 Wisconsin Ave Bethesda, Md	25a. REC'D BY REGISTRAR SEP 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					



CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Ethel Irene Breslin</i>	Middle	Lost	2a. DATE OF DEATH Month <i>9</i>	Doy <i>22</i>	Year <i>68</i>	2b. HOUR <i>90. M.</i>	
3. SEX <i>Female</i>	4 RACE <i>White</i>	S. DATE OF BIRTH <i>6-17-05</i>	6 AGE (In years at death) <i>63 yrs.</i>	IF UNDER 1 YEAR MONTHS <i>1</i>	IF UNDER 24 HRS. DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>America</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington San. Hosp.</i>	12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired) <i>Housewife</i>						
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE <i>maryland</i>	13b. COUNTY <i>montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIM. TSC YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>1013 Hollywood Ave</i>				
14. FATHER'S NAME First <i>Edward</i>	Middle <i>Todd</i>	15. MOTHER'S Maiden NAME First Middle <i>Mary</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>147-34-0001</i>	17. INFORMANT <i>Hospital Record</i>	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>abdomen lungs, spine, rt femur.</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs plus</i>				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>General metastatic Carcinoma</i>								
(b) <i>Carcinoma of rectosigmoid, small</i>								
DUE TO, OR AS A CONSEQUENCE OF (c) <i>bowel and appendix & peritoneum</i>				<i>2 1/2 yrs ±</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)								
19a. DATE OF OPERATION <i>5-16-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca sigmoid, ileum, appendix</i>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>—</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC.) <i>—</i>	21f. LOCATION Street or R.F.D. No. <i>—</i>	City or Town <i>—</i>		County <i>—</i>	State <i>—</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>5-6-68, 19</i> , to <i>9-22, 1968</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. S.G.NAT.R.E <i>Read N. Calvert M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9-22-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>READ N. CALVERT</i>		22e. ADDRESS <i>909 Pershing Dr. Silver Spring, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>At Marks</i>		23b. DATE <i>Sept 25, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>—</i>	23d. LOCATION (City or Town) <i>Fairland Mortg Co. Md.</i>	23e. (County) <i>—</i>	(State) <i>—</i>		
24. FUNERAL DIRECTOR <i>Takoma Funeral Home Inc. 254 Carroll St NW</i>		ADDRESS <i>—</i>	25a. REC'D BY REGISTRAR DATE SEP 24 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death sentence be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, written 2 hours after death.

VR A15 {4}
30M REV. 1/68

13077

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13089

CERTIFICATE OF DEATH

DECEASED NAME (Type or print)		First Juttie	Middle Lee	Last Brizendine	2a DATE OF DEATH Month September Day 30, 1968 Year \$35 M	2b HOUR	
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 20, 1925		6. AGE (In years last birthday) 43	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission). STATE Virginia		13b. COUNTY Boteourte		13c. CITY OR TOWN Daleville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER P. O. Box 102	
14. FATHER'S NAME Shelton	First Middle Crane	Lost		15. MOTHER'S MAIDEN NAME Vinita	Middle	Lost Cash	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO. 265-22-1543		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
174 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration pneumonitis					8 Hours
		DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Breast Carcinoma					2 Months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION 19c. TIME OF INJURY Hour A.M. Month Day Year <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19d. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. LOCATION Street or R.F.D. No. City or Town County State		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		30	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 3, 1968, to September 19, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 30, 1968, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) <input type="checkbox"/> view the body after death.							
22b. SIGNATURE C. Wayne Bardin		DEGREE	ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 1 October 1968	
22d. PHYSICIAN'S NAME (Type) C. Wayne Bardin, MD.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		23b. DATE 10-468	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS The Clinical Center, NIH		23d. LOCATION (City or Town) Troutville		(County) Va. (State)
24. FUNERAL DIRECTOR W.W. Chambers		ADDRESS 1400 Chapel St. NW.	25a. REC'D BY REGISTRAR DATE OCT 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

2

1

2

3

4 5

6

7

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, from the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, from the director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13073			MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH						13090						
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR						
KARL			FREDERICK	BRODT		9	Month	26	Year	5:30	P.M.				
3. SEX			4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)			IF UNDER 1 YEAR					
MALE			CAUCASIAN		7 Feb 1879		89 yrs.			MONTHS	DAYS				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED	<input type="checkbox"/>	WIDOWED	<input checked="" type="checkbox"/>	DIVORCED	<input type="checkbox"/>	9. COUNTY OF DEATH		
WASHINGTON DC			USA										Montgomery		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
KENSINGTON			3615 SAUL RD.			REAL ESTATE			BROKER						
13a. USUAL RESIDENCE (Where deceased lived, if institut admission) STATE COUNTY			13c. CITY OR TOWN			13d. INSIDE CTY LIMITS?			13e. STREET AND NUMBER						
MD MONTGOMERY CO.			KENSINGTON			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3615 Saul Rd. Kensington Md.						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last				
Wilhelmus F.					BRODT	HELENA					BOLZ				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address						
X Spzn. Amer. War			578-05-4995			Son			3615 Saul Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).															
PART 1. DEATH WAS CAUSED BY.															
IMMEDIATE CAUSE (a) Cordae Arrhythmia															
4127 DUE TO, OR AS A CONSEQUENCE OF 5 min															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arteriosclerotic Heart Disease															
DUE TO, OR AS A CONSEQUENCE OF 10 yrs															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County	State				
22a. I certify that (I) (this hospital) attended the deceased from JAN 1968, to AUG 1968, that (I) (we) last saw the deceased alive on AUG 25 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.															
22b. SIGNATURE Eugene P. Libre MD															
DEGREE		ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED 26 Sept 68							
22d. PHYSICIAN'S NAME (Type)		EUGENE P. LIBRE			22e. ADDRESS 10400 Corn. Ave. Kensington Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9-28-1968		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d. LOCATION (City or Town) Suitland, Prince Georges Co., Md.		(County)		(State)				
24. FUNERAL DIRECTOR Joseph Sawyer's Sons, Inc., N.W., Wash., D.C., 20016		ADDRESS 530 Wisc. Ave.						25a. RECD BY REGISTRAR DATE SEP 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13079 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13091

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR
		Bill	Tom	BARNES Brown	Sept 9	1968	12:35 P.M.		
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS	16 UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
m	w	Aug 6 1945	66 23RS			Sept 9	1968	10:00 A.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			
Virginia		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if ret'd)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital			Housewife			House	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Maryland		Montgomery		Bernardston	YES <input type="checkbox"/> NO <input type="checkbox"/>	Box 263 Middlebrook Rd.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle
Reese		w.		Brown	Mary			Lambert	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes		1465-New Haven		Oakcrest 199, 10 ADDRESS - Bernstein N.Y.			minutes		
Reese Brown Jr. (brother) Lambert									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-pulmonary hemorrhage, massive</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Automobile Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>022-1</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR AM		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			21d. LOCATION Street or R.F.D. No City or Town County State		
21d. INJURY OCCURRED WHILE NOT WORK AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, off building, etc)		21f. LOCATION Street or R.F.D. No Route 37 at Cedargrove Damaskos Mont. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town, or County)			22b. DATE SIGNED	
EXAMINER'S NAME (Type)								Sep 9, 1968	
23a. BURIAL, CREMATON, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)	(State)
Burial		9-12-68		Tazewell		Tazewell		Va	
24. FUNERAL DIRECTOR		Ernest C. Gartner		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
		Finest C. Gartner Gaithersburg		MD		SEP 11 1968		Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

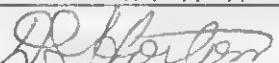
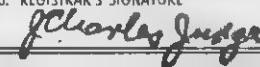
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13080

13092

1. DECEASED-NAME (Type or print)	First George	Middle L.	Last Brown	2a. DATE OF DEATH Month Sept.	Day 18	Year 68	2b. HOUR A 845 M	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH Aug. 11, 1939		6. AGE (In years last birthday) 29	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Conn.	13b. COUNTY	13c. CITY OR TOWN Groton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 63 Walker Hill Road				
14. FATHER'S NAME First Cecil W. Brown	Middle	Last	15. MOTHER'S MAIDEN NAME Pauline Malone	Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes	16b. SOCIAL SECURITY NO. 1959-68	17. INFORMANT Navy Records	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Mesothelioma of pleura with widespread metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cal examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from Aug. 28, 1968, to Sept. 18, 1968, that (I) (we) last saw the deceased alive on Sept. 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE 		DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED Sept. 18, 1968
22d. PHYSICIAN'S NAME (Type)		D. L. HORTON, M. D.		22e. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-22-68	23c. NAME OF CEMETERY OR CREMATORIAL FT ASHBY CEMETERY	23d. LOCATION (City or Town) FT. ASHBY, WEST VIRGINIA		(County) (State)		
24. FUNERAL DIRECTOR		W. W. CHAMBERS COADDRESS 1400 CHAPIN ST., N.W. WASHINGTON, D. C.		25a. REC'D BY REGISTRAR DATE SEP 26 1968	25b. REGISTRAR'S SIGNATURE 			



13093

13081

CERTIFICATE OF DEATH

First Bertha			Middle Lee	Last Bryant	2a. DATE OF DEATH Sept. 23	Month 23	Day 68	Year 41:00			
3. SEX Female	4. RACE White		5. DATE OF BIRTH 8-28-03		6. AGE (In years last birthday) 85		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. HOURS 0		
7a. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Woodbine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 1			
14. FATHER'S NAME First Went Stubblefield		Middle	Last	15. MOTHER'S MAIDEN NAME First UNKNOWN		Middle Brewer	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO 214-26-6426		17. INFORMANT Hospital Records		Address Olney, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bile nephrosis & anuria + uremia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Fibroid cirrhosis of liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks. 6 mos.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Bronchopneumonia and congestive heart failure</i>											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			21f. LOCATION Street or RFD No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1968, to Sept. 23, 1968, that (I) (we) last saw the deceased alive on Sept. 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Frederick Moonan M.D.</i>		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS		22c. DATE SIGNED 9-23-68			
22d. PHYSICIAN'S NAME (Type) Dr. Frederick Moonan	22e. ADDRESS Medical Center, Sandy Spring, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 25, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Oak Grove			23d. LOCATION (City or Town) Glenwood		(County) Howard		(State) Mont		
24. FUNERAL DIRECTOR Francis H. Barber	ADDRESS Laytonsville, Md. 20760	25a. REC'D BY REGISTRAR DATE SEP 25 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13082

CERTIFICATE OF DEATH

13094

1. DECEASED NAME (Type or print)	First Charles	Middle S.	Last BRYANT	2a DATE OF DEATH Sept. Month 10 Day 68 Year	2b HOUR 128P M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH Jul.19, 1919		6 AGE (In years last birthday) 49 yrs	F UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Air Force		12b. KIND OF BUSINESS OR INDUSTRY McLaren Court
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia	13b. COUNTY Fairfax	13c. CITY OR TOWN Fairfax	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9813 McLaren Court	
14. FATHER'S NAME Charles S.	Middle Bryant	Last	15 MOTHER'S MAIDEN NAME Mary	Middle	Last Lumley
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	16b SOCIAL SECURITY NO 1942-68	17 INFORMANT Hospital records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Status Post-operative aortic valve DUE TO, OR AS A CONSEQUENCE OF prosthesis for calcific aortic stenosis (Bicuspid valve) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Severe occlusive coronary atherosclerotic disease					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day					
19a DATE OF OPERATION Sep. 11, 1968	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Calcific aortic stenosis	20a AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 7, 1968, to Aug. 10, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 10, 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE W. F. BEASLEY	22c. DATE SIGNED Sept. 11, 1968				
22d. PHYSICIAN'S NAME (Type) W. F. BEASLEY	22e. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-16-1968	23c. NAME OF CEMETERY OR CREMATORIAL —	23d. LOCATION (City or Town) TAMPA	(County)	(State) FLA.
24. FUNERAL DIRECTOR W. W. Chambers Co.	ADDRESS 1400 Chapin Street, N.W., Washington, D.C.	25a REC'D BY REGISTRAR DATE SEP 13 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, ages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

John P. Hart

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
13083

CERTIFICATE OF DEATH

13095

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3, 4, and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San & Hospital			d. STREET ADDRESS 8318 26th Ave.,		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby Boy		First Baby Boy	Middle Buelter	4. DATE OF DEATH Sept. 21, 1968	Month 19 Year 68
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1968	9. AGE (in years lost birthday) yrs .. yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N ne			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State or foreign country) Montgomery, Maryland
13. FATHER'S NAME Hubert Thomas Buelter			14. MOTHER'S MAIDEN NAME Arita Ludmila Kronska		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Hubert Thomas Buelter Adelphi, Md.	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Placenta DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Prematurity DUE TO (c) Premature Separation Placenta					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 951 Spring St.	20f. (City or town) Adelphi	(County) (State) 951 Spring St.
21. I certify that (I) (this hospital) attended the deceased from Sept. 21 @ 3:45 p.m. , to Sept. 21 @ 9:55 p.m. , 1968, that (I) (we) last saw the deceased alive on Sept. 21 1968, and that death occurred at 9:55 p.m. , from causes and on the date stated above.					
22a. SIGNATURE Ronald Chin		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/21/68
22c. PHYSICIAN'S NAME (Type) R. Chin, M.D.		22d. ADDRESS 1110 Spring St., Silver Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9-22-68	23c. NAME OF CEMETERY OR CREMATORIAL Washington San & Hospital Takoma Park, Montgomery, Md.	23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR J. D. Ruffcorn		ADDRESS 7706 Carroll Ave., Tk Pk. Md.	25a. REC'D BY REGISTRAR SEP 25 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13084

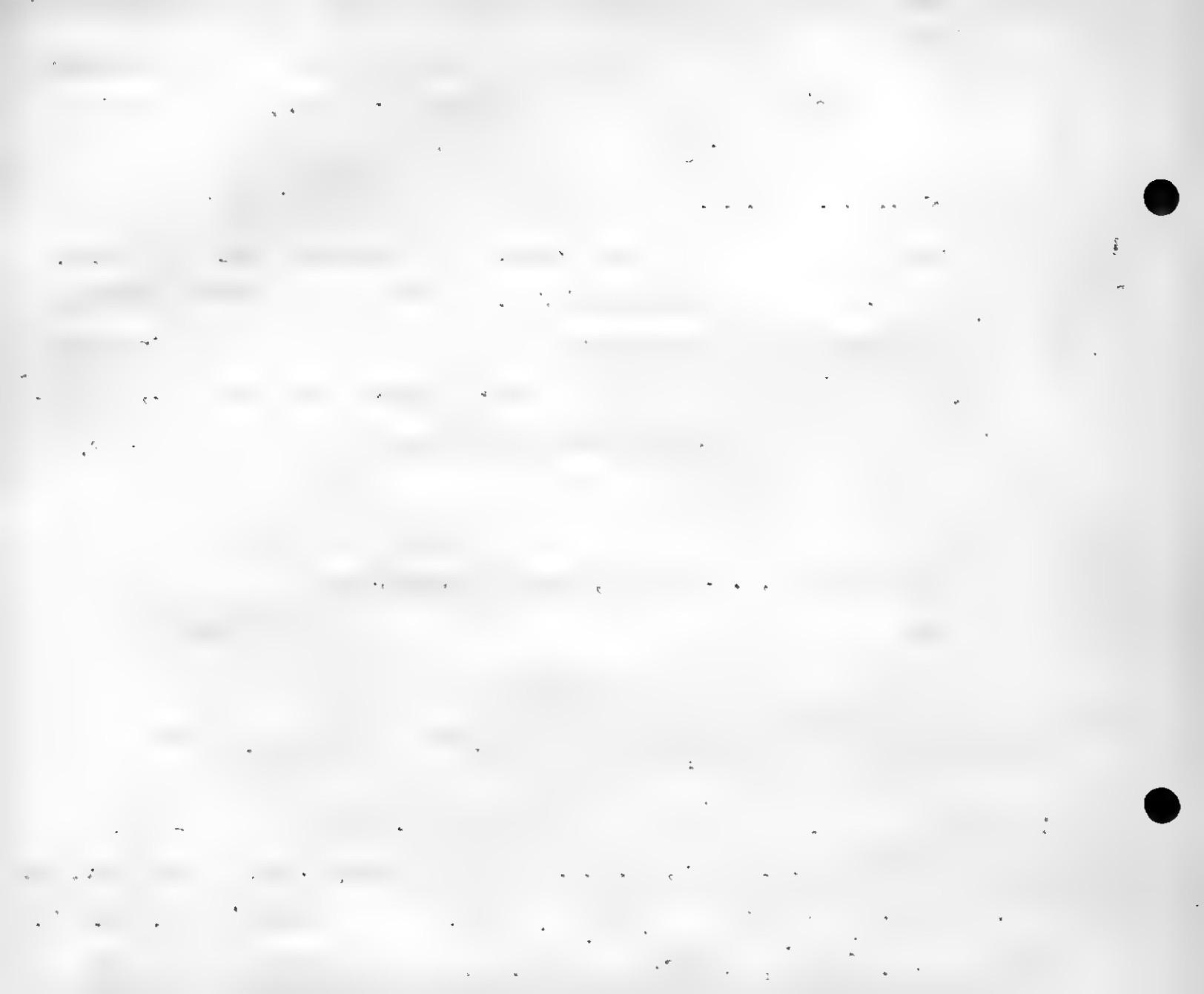
CERTIFICATE OF DEATH

13096

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>John</i>	Middle <i>NM</i>	Last <i>Bullough Jr.</i>	2a. DATE OF DEATH Month <i>Sept.</i>	Day <i>26</i>	Year <i>1968</i>	2b. HOUR <i>05 AM</i>		
3. SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>12/19/91</i>		6. AGE (In years last birthday) <i>76 yrs.</i>		IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	HOURS <i>00</i>
7a. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>				
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Insurance Agent</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Insur. Co.</i>				
13a. USJAL RESIDENCE (Where deceased lived, if institution Res.dence before admission) STATE <i>Md.</i>		13c. CITY OR TOWN <i>Montgomery Sil. Spr.</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>2021 Hanover Street</i>				
14 FATHER'S NAME First <i>John</i>		Middle <i>Bullough</i>	Last	15 MOTHER'S MAIDEN NAME First <i>Alice</i>		Middle	Last <i>Van Ness</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> pr unknown		16b. SOCIAL SECURITY NO <i>579-44-3993</i>		17. INFORMANT <i>Mabel Bullough</i>		Address <i>2021 Hanover St., Sil. Spr.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured Abdominal Aneurysm</i> 4412 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause lost. 4512 DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Bleeding gastric, peptic ulcer, cardiac decompensation</i>										
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 12, 1968</i> , to <i>Sept. 26, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept. 25, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Bennet A. Porter, Jr. M.D.</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.		22d. DATE SIGNED <i>9-27-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>Bennet A. Porter, Jr. M.D.</i>		22e. ADDRESS <i>9301 Colesville Road, Silver Spring, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (check)		23b. DATE <i>9-28-68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Suitland</i>		(County) (State) <i>Pt. Geo. Md.</i>		
24. FUNERAL DIRECTOR <i>M. Andrew Duvall</i>		ADDRESS <i>Warren E. Pumphrey, Inc. 8434 Ga. Ave. Sil. Spr.</i>		25a. REC'D BY REGISTRAR <i>OCT 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>				

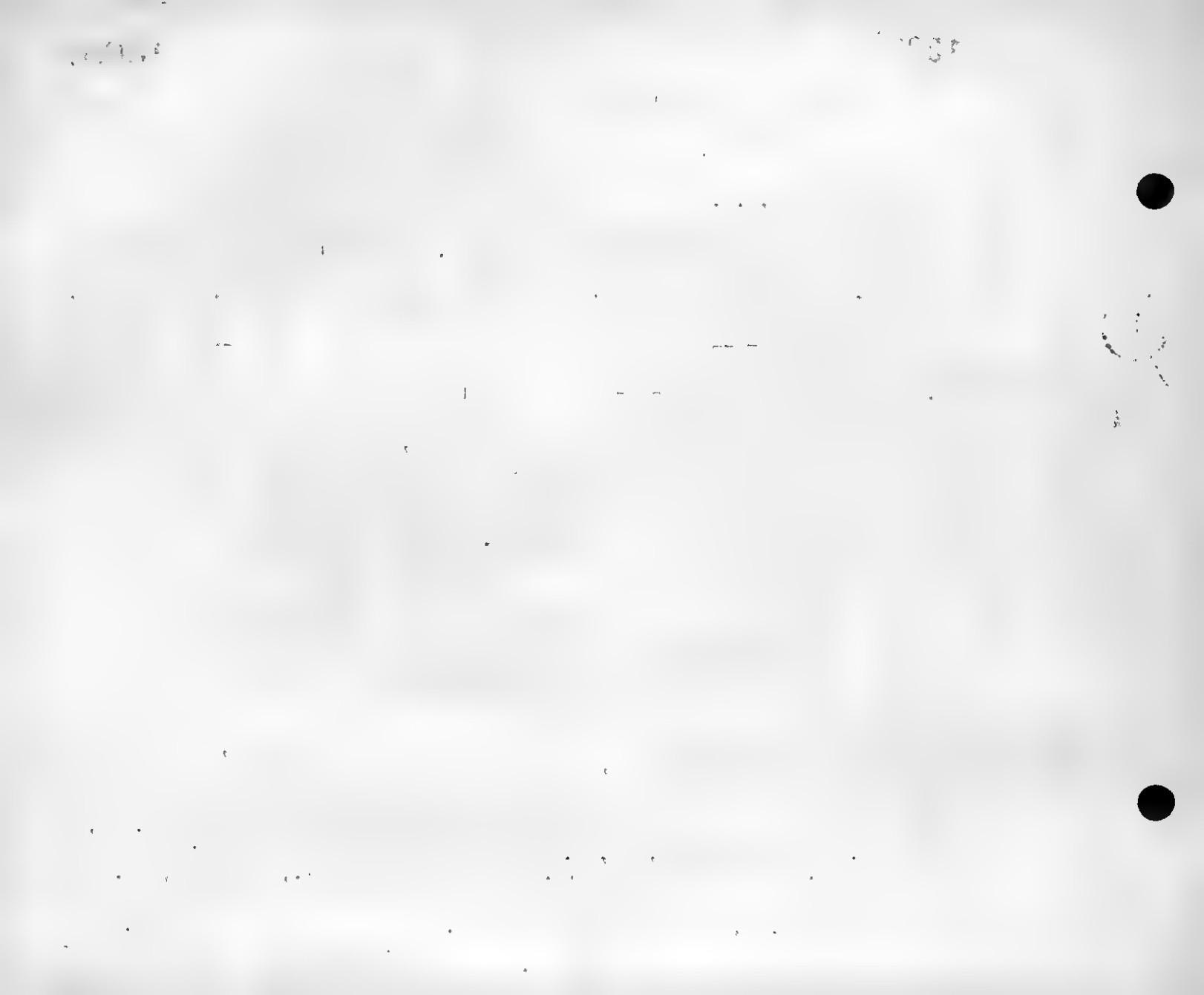


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13097

1. DECEASED NAME (Type or print)	First EMILY	Middle LORRAINE	Last BURDETTE	2a. DATE OF DEATH Month 9 Day 18 Year 68	2b. HOUR 6:20 AM				
3. SEX FEMALE	4. RACE WHITE	S. DATE OF BIRTH 5/1/03	6. AGE (in years last birthday) 65	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0		
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY						
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) MONTGOMERY GENERAL HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN DAMASCUS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 26023 MT. VERNON AVE.					
14. FATHER'S NAME First HARRY	Middle ---	Last MOXLEY	15. MOTHER'S MAIDEN NAME First ELEANOR	Middle ---	Last HYATT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNK.	16b. SOCIAL SECURITY NO 213-01-5877	17. INFORMANT MEDICAL RECORDS	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident, probably DUE TO, OR AS A CONSEQUENCE OF thrombosis with left hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) thrombosis DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardio-vascular (c) disease.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) No accident							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 1958 , 19 68 , to Sept 18 , 19 68 , that (I) (we) last saw the deceased alive on September 18, 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Kendree Boyer</i>	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Sept. 19, 1968				
22d. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.	22e. ADDRESS 9701 CHURCH ST., DAMASCUS, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 21, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Damascus Meth.	23d. LOCATION (City or Town) Damascus, Md.	(County)		(State)			
24. FUNERAL DIRECTOR Olin L. Modesworth, Damascus, Md.	ADDRESS	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						
VR A15 30M REV	DATE	SEP 23 1968							



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 may be retained for your files.

13086

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13098

1. DECEASED-NAME (Type or Print)		First	Middle	. ^{DST}	2a DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b HOUR		
		<i>Mary KATHRYN BURRUS</i>			9-7	1968			M		
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE, IN YEARS	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS DAYS	9. HOURS	MIN	2d HOUR			
Female	White	Nov. 25, 1911	56 yrs					8:15 P.M.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH		2c DATE PRONONCED DEAD Month Day Year			
Wisc.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		Sept. 2	1968	8:15 P.M.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		5415 DuVALL DR.			Housewife			own home			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS	13e STREET AND NUMBER					
Md. Montgomery		Bethesda		Bethesda	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	5415 - DuVALL Dr.					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
GEORGE				KENNEY	UNKNOWN						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		ADDRESS: 5415 DuVALL DR. JEFFERSON D. BURRUS Westmorland Hills, MD					
No		578-62-9667		Jefferson D. Burrus							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infarction of brain stem</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>accompanied by massive pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>R. Belden R. Peap</i>		M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2b. DATE SIGNED Sept. 3, 1968		
EXAMINER'S NAME (Type) <i>BELDEN R. PEAP M.D.</i>		M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Leave blank if same as above county)				
23a. BURIAL, CREMATION REMOVAL (Check one)		23b. DATE SEPT. 6, 1968		23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL Crematory		23d. LOCATION (City or Town) SUITLAND		(County)	(State)		
24. FUNERAL DIRECTOR <i>Tos. Grawlers Sons Inc.</i>		ADDRESS 5130 WISCONSIN AV. N.W. WASHINGTON D.C.			25a. REC'D. BY REGISTRAR SEP 6 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15ME (5) 10M REV. 1/6											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13087

13099

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Poets Land 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First ERNA	Middle	Lost BUSH	2a. DATE OF DEATH Month Sept. 21, 1968 Year	2b. HOUR 12:15 A.M.
3. SEX Female	4. RACE Caucasian	S. DATE OF BIRTH Sept. 21, 1892	6. AGE (In years lost birthday) 76 yrs.	F. UNDER 1 YEAR MONTHS DAYS	I. IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Washington	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	Md.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5415 Beech Ave.	
14. FATHER'S NAME First Henry	Middle Olschewsky	15. MOTHER'S MAIDEN NAME First Laura Bartram	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 579-44-7180B	17. INFORMANT Husband George Bush	Address Same as Item 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sev. hour</u> 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) (b) <u>Multiple Cerebral Thromboses</u> sev. months stating the underlying cause lost. 403X DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive cardiovascular disease, long yrs</u> <u>Diabetes Mellitus - atrial fibrillation</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>9-15</u> , 19 <u>68</u> , to <u>9/21, 1968</u> , that (I) (<input checked="" type="checkbox"/> we) last saw the deceased alive on <u>9/20</u> 19 <u>68</u> , and that in (my) (<input checked="" type="checkbox"/> our) opinion death occurred on the date and hour and from the causes stated above, (I) (<input checked="" type="checkbox"/> we) (<input checked="" type="checkbox"/> did not) view the body after death.					
22b. SIGNATURE <u>G. H. Mitchell</u>	DEGREE ATTENDING PHYS	A.M. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>9/21/68</u>		
22d. PHYSICIAN'S NAME (Type) G. H. MITCHELL	22e. ADDRESS 11125 Rockville Pike Rockville, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 9-24-68	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	23d. LOCATION (City or Town) Suitland, Maryland	(County)	(State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland	ADDRESS BETHESDA, Maryland	25a. REC'D BY REGISTRAR DATE SEP 27 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



Robert L. Snowden
1
13089
Item #13b,c,e, File #104 9/20/68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

D. John Bell 13089/1968

1. DECEASED NAME (Type or print)	First <i>Elgie M</i>	Middle <i>Butler</i>	Last <i>Butler</i>	2a. DATE OF DEATH Month <i>8</i>	Year <i>68</i>	2b. HOUR <i>4 AM</i>
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>2/19/98</i>		6. AGE (In years last birthday) <i>70</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Grosvenor Lane Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Montgomery</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>130 Norbeck Rd.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Mont.</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>5721 Grosvenor Lane Bethesda</i>		
14. FATHER'S NAME First <i>MANSFIELD</i>	Middle <i>BUTLER</i>	Last	15. MOTHER'S MAIDEN NAME First <i>ELIZABETH</i>	Middle	Last <i>RIGGS</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. <i>000-00-0000</i>	17. INFORMANT	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ca of Prostate with generalized metastasis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>						
19a. DATE OF OPERATION <i>1/1/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <i>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></i>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>None</i>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>None</i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>None</i>	21f. LOCATION Street or R.F.D. No. <i>None</i>	City or Town <i>None</i>	County <i>None</i>	State <i>None</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>8/3/68</i> , 19 <i>68</i> , to <i>9/6/68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9/6/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) <input type="checkbox"/> (did not) view the body after death.						
22b. SIGNATURE <i>Timothy James Tolson was</i>		DEGREE <i>None</i>	ATTENDING PHYS. <i>None</i>	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>9/9/68</i>
22d. PHYSICIAN'S NAME (Type) <i>Dr. Timothy Tolson Dr. John C. Coker</i>		22e. ADDRESS <i>5216 Wisconsin Avenue Bethesda MD 20816</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>9-11-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>BROOKE GROVE CEM.</i>	23d. LOCATION (City or Town) <i>LAYTONSVILLE, MONTG. MD.</i>	(County) <i>MONTG.</i>	(State) <i>MD.</i>	
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>	ADDRESS <i>ROCKVILLE, MD</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13089

13101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print).	First	Middle	Lost	2a. DATE OF DEATH Month	2b. HOUR Year
<i>Anna G. X</i>		<i>Campbell</i>		<i>September 18 1968</i>	<i>11 PM</i>
3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (in years lost birthday)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS DAYS HOURS MIN
<i>Female</i>	<i>white</i>	<i>1-24-84</i>	<i>84 yrs.</i>		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Maryland</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a. USUAL OCCUPATION (kind of work done during most working life, even if retired) <i>Retired Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Maryland</i>	13c. CITY OR TOWN <i>Takoma Park</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>12405 Stalls Rd -</i>	
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
<i>Robert</i>		<i>Glick</i>	<i>Mrs. James T. Furlow</i>	<i>sec # 13</i>	<i>Barber</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. <i>220-46-2865</i>	17. INFORMANT <i>Mrs. James T. Furlow</i>	Address <i>see # 13</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arterio Sclerosis</i> <i>yes -</i></p> <p>(b) <i>Arterio Sclerosis</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) <i>Occultusion Femoral Artery</i> <i>4 days</i></p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)</p> <p><i>Sept 11</i></p>					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 11, 1968</i> , to <i>Sept 18, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 18, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Harris M. Kenner MD</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>9/19/68</i>	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <i>5411 Cedar Lane Bethesda MD</i>				
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9-23-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>	23d. LOCATION (City or Town) <i>Silver Spring, Maryland</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Joseph Tawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE		
DATE <i>SEP 23 1968</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

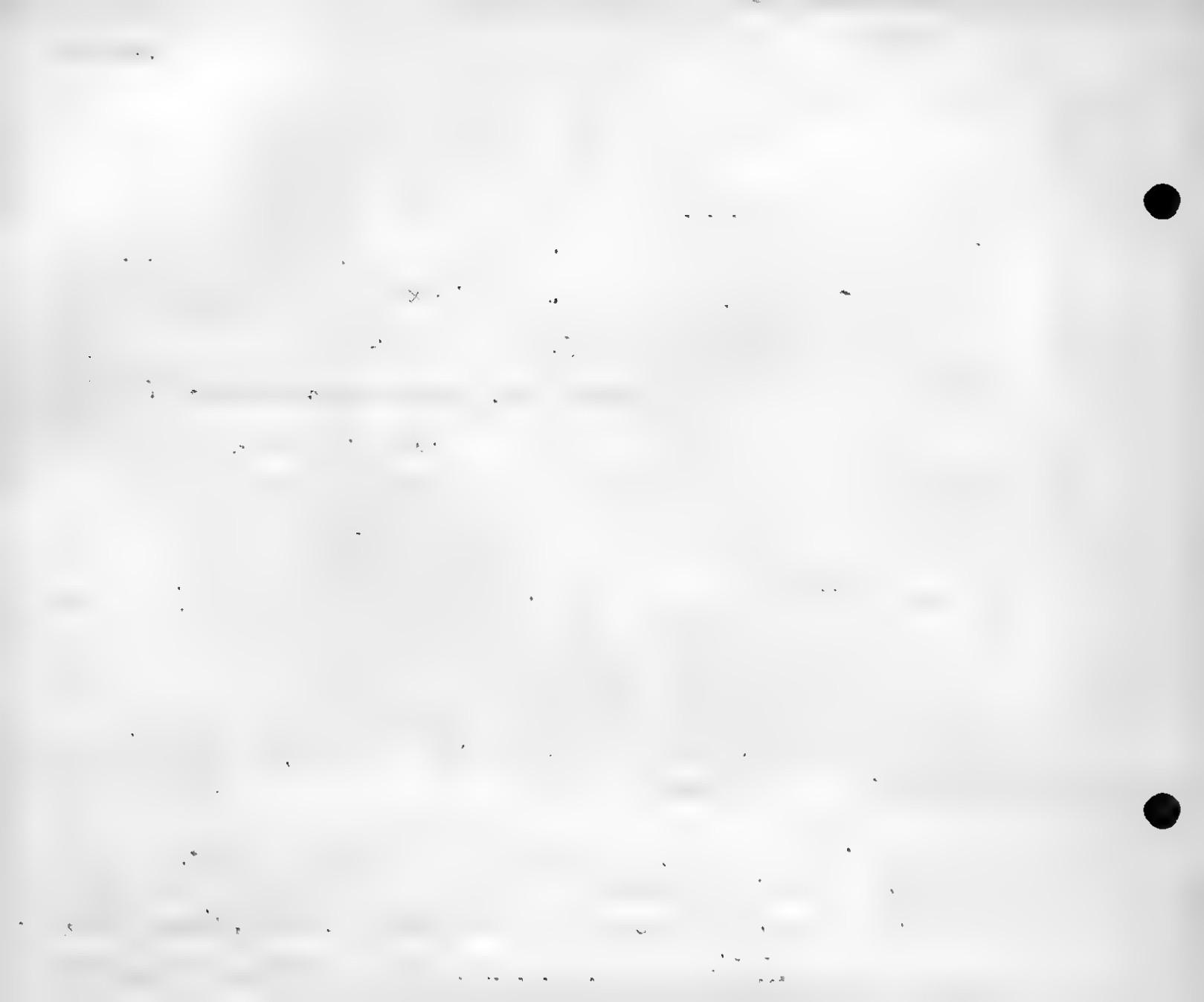
13090

13102

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR Hour
Hugh A. CAMPBELL, JR.				9	17	68	8:35 AM
3. SEX	4 RACE	S. DATE OF BIRTH	6/24/94				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
MALE	WHITE	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH MONTGOMERY				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Inspector	
VIRGINIA	U.S.A.					12b. KIND OF BUSINESS OR INDUSTRY Schools	
10. CITY OR TOWN OF DEATH	13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.				13c. CITY OR TOWN	3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2112 SEMINARY RD.
SILVER SPRING	13b. COUNTY MONTGOMERY				Silver Spring		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
John Alexander Campbell				Martha Curtin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. 578-46-7932	17. INFORMANT Mrs. Claudia Campbell 2112 Seminary				Address Sil. Sop. Rd. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of head of pancreas</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>wide spread visceral metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Emphysema and arteriosclerotic heart disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (year)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Emphysema and arteriosclerotic heart disease</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town	County State
22a. I certify that (I) (This hospital) attended the deceased from <i>January 1968</i> to <i>Sept. 17, 1968</i> , that (I) (we) last saw the deceased alive on <i>9-17 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. A. BROWN, M.D.</i>							
22d. PHYSICIAN'S NAME (Type)		DEGREE J. A. BROWN, M.D.	ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-17-68	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE 9-20-1968	23c. NAME OF CEMETERY OR CREMATORIAL Cebal's or St. Paul Cemetery		23d. LOCATION (City or Town) Cebal's, Silver Spring, MD.	(County) Montgomery Co., MD.	(State)
24. FUNERAL DIRECTOR John W. Lee		ADDRESS Montgomery, Inc. 8434 Ga. Ave. S.S. #11	25a. REC'D BY REGISTRAR DATE SEP 20 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

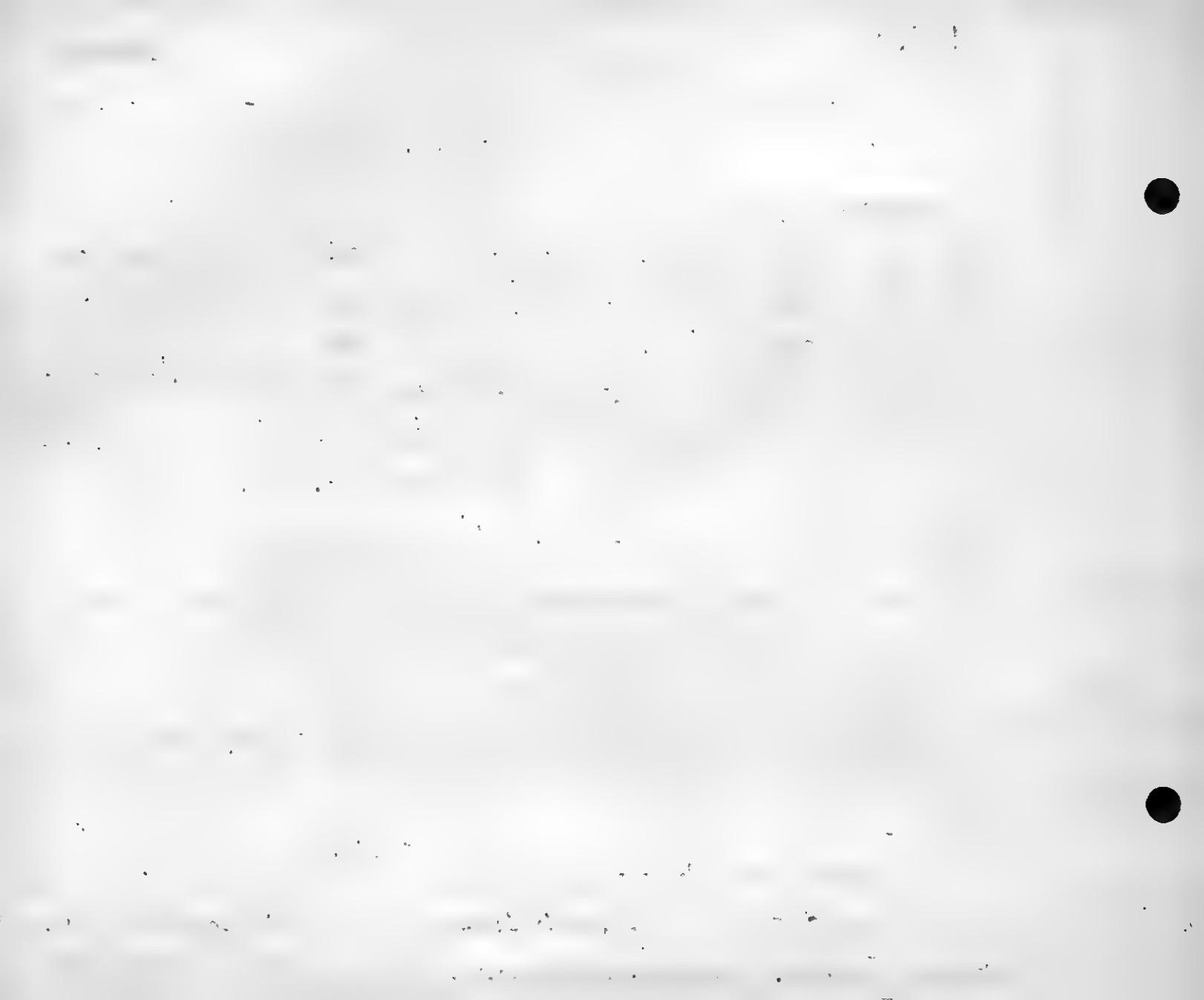
13091

13103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>MARGARET</i>	Middle <i>G</i>	Last <i>CARNahan</i>	2a DATE OF DEATH Month <i>Sept</i>	Day <i>27</i>	Year <i>1968</i>	2b HOUR <i>3 45 P.M.</i>	
3 SEX <i>Female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>7/5/1880</i>		6. AGE (in years last birthday) <i>88</i>		IF UNDER 1 YEAR MONTHS <i>YRS</i>		
7a BIRTHPLACE (State or foreign country) <i>Scotland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>MONTGOMERY</i>				
10. CITY OR TOWN OF DEATH <i>Kensington</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>KENSINGTON Gardens Sanatorium</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b COUNTY <i>MONTGOMERY</i>	13c CITY OR TOWN <i>SILVER SPRINGS</i>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>704 FOREST Glen Rd</i>				
14 FATHER'S NAME First <i>Alexander</i>	Middle <i>GASKIN</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Mary</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <i>No</i>	16b SOCIAL SECURITY NO (If yes give war or dates of service) <i>219-46-9057</i>	17 INFORMANT <i>Mrs. Stanley West</i>	Address <i>Silver Spring, Md.</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic cerebral & coronary insufficiency</i>								
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic cardiovascular disease</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION <i>4/1/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>While at work</i>	21b. TIME OF INJURY Hour A.M. Month Day Year <i>P.M. 19</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>At home</i>	21f LOCATION Street or R.F.D. No. <i>345 University Blvd., W.</i>	City or Town <i>Silver Spring, Md.</i>		County <i>Prince George's Co.</i>		State <i>Md.</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 30, 1967</i> , to <i>Sept 27, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 27, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Raymond Bradshaw, MD</i>		22c. DATE SIGNED <i>Sept 27, 1968</i>						
22d. PHYSICIAN'S NAME (Type) <i>Raymond Bradshaw, M.D.</i>	22e. ADDRESS <i>345 University Blvd., W.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE <i>9-29-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lincoln Crematory</i>	23d. LOCATION (City or Town), (County), (State) <i>Prince George's, Md.</i>					
24. FUNERAL DIRECTOR <i>Clare C. Wison</i>	ADDRESS <i>Clarksville</i>	25a. REC'D BY REGISTRAR DATE <i>OCT 2 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13092

13104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 3 should be detached for use as the burial/transit permit. Then please leave carbon papers. Pages 1 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 15 ¹⁵ 11 P.M.
JAMIE L. CARTER				September 21 1968	
3. SEX	4. RACE	S. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White	6-25-1912	56 yrs		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
Alabama	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Montgomery		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
Bethesda	Suburban		Homemaker		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland	Montgomery	Kensington	YES <input checked="" type="checkbox"/>	10307 Armory Ave.	
14. FATHER'S NAME	First	Middle	15. MOTHER'S MAIDEN NAME	First	Middle
Reily		Henderson	Lela	Hammond	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIA. SECURITY NO.	17. INFORMANT	10307 Armory Ave.		
No	087-26-2567	Mr. Charles M. Carter, Kensington, Md.			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pulmonary Insufficiency of Paroxysms At 1085 Anschus 10 days</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Embolism</u>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Myocardial Dystrophy</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (i) (this hospital) attended the deceased from <u>Aug 6</u> , 1968, to <u>Sept 21, 1968</u> , that (ii) I last saw the deceased alive on <u>21 Sept 1968</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (iii) <input type="checkbox"/> we <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE <u>Eugene P. Lebre</u>		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>22 Sept 68</u>
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <u>10400 Concourse Ave</u>		<u>Washington DC</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/25/68	23c. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery	23d. LOCATION (City or Town) Penns Grove, Salem Co. N.J.	(County)	(State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.	7557 ADDRESS ROBERT A. PUMPHREY, Bethesda, Md.	25a. REC'D. BY REGISTRAR SEP 27 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

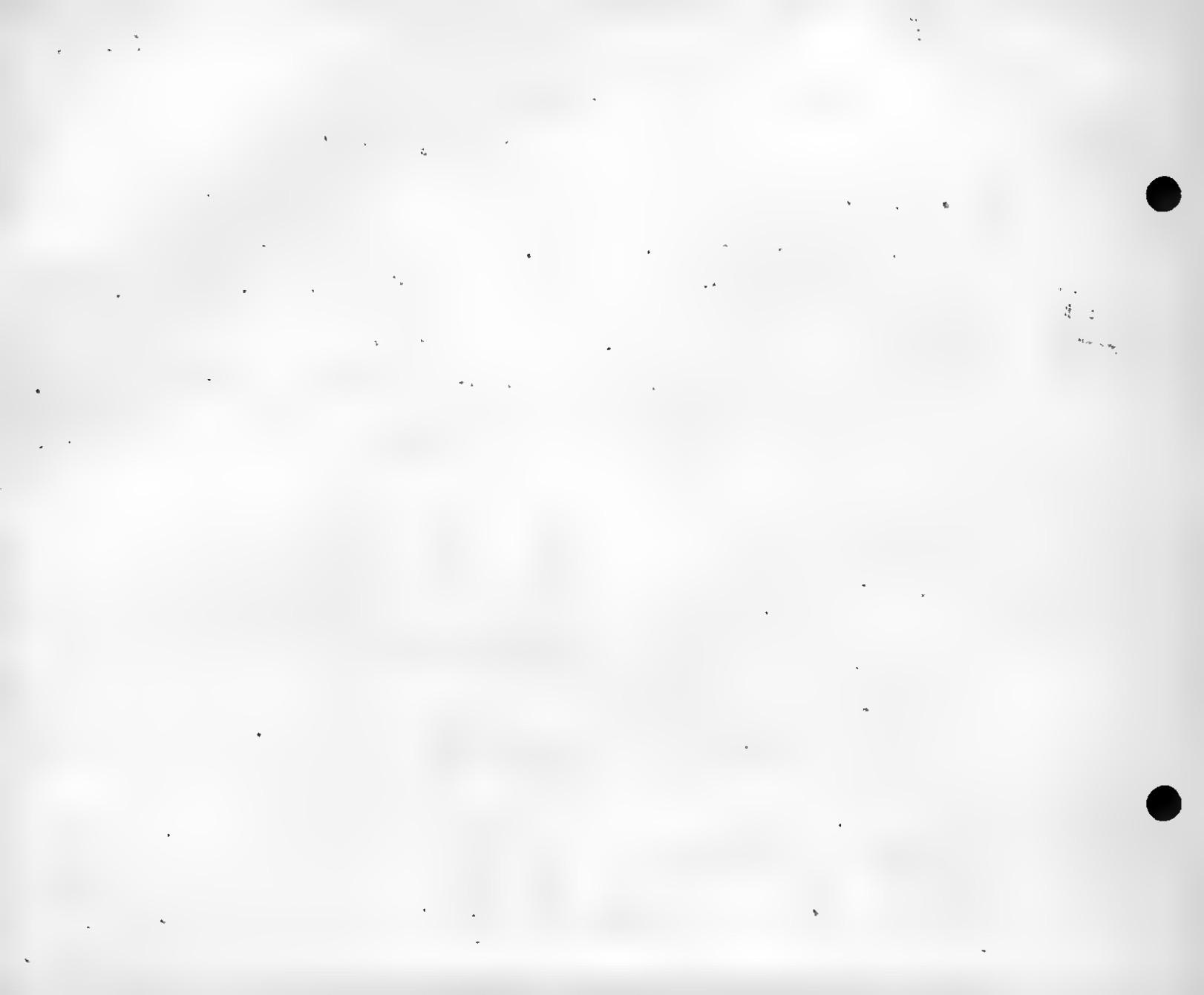
1309?

13105

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First HARRY	Middle CHIDAKEL	Last	2a. DATE OF DEATH Month 13 Day 1 Year 1968	2b. HOUR 3:15 P.M.
3 SEX MALE	4. RACE WHITE	5 DATE OF BIRTH DEC. 25, 1893	6 AGE (In years last birthday) 74 yrs.	F UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0
7a. BIRTHPLACE (State or foreign country) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY	Md.	
10 CITY OR TOWN OF DEATH SILVER SPRING	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8101 EASTERN	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MERCHANT	12b. KIND OF BUSINESS OR INDUSTRY EASTERN AVENUE		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c CITY OR TOWN SILVER SPRG.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 8101 EASTERN AVENUE	
14 FATHER'S NAME First SAMUEL	Middle CHIDAKEL	Last	15 MOTHER'S MAIDEN NAME First UNKNOWN	Middle	Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO 577-16-3693	17 INFORMANT SOH-IN-LAW CHARLES M. PASCAL	Address WASIT DC 1919 PARKSIDE DR. NW	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Paralysis Agitans - 15 years.					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) at work <input type="checkbox"/>	21d. LOCATION Street or R.F.D. No. 1001 - 10th St., N.W.; Washington, D.C. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Aug. 31, 1968 , to Sept. 13, 1968 , that (I) (we) last saw the deceased alive on Aug. 8, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.					
22b. SIGNATURE Warren D. Brill, M.D.	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Sept. 13, 1968	
22d. PHYSICIAN'S NAME (Type) Warren D. Brill, M. D.	22e. ADDRESS 1001 - 10th St., N.W.; Washington, D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-15-68	23c. NAME OF CEMETERY OR CREMATORIAL KESHER-ISRAEL CEM. HILLSIDE	23d. LOCATION (City or Town) HILLSIDE	(County) M.D.	(State)
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS - WASIT DC	ADDRESS ADDRESS	25a. REC'D BY REGISTRAR SEP 19 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PHM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13094

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13106

1. DECEASED NAME (Type or Print)							First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR
George Anthony Claps									<input checked="" type="checkbox"/>	9	14	1968	4 PM	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS DAYS	9. IF UNDER 24 HRS HOURS	10. DATE PRONOUNCED DEAD Month	11. DATE PRONOUNCED DEAD Day	12. DATE PRONOUNCED DEAD Year	12a. HOUR				
male	white	3/22/1891	77 yrs				9	14	1968	12 PM				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.						
New York		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring			1074 Cross			Mechanical Drafts. Manuf.								
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER					
Florida			Sarasota Sarasota			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3334 Savage Road					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
Vito			NMI	Claps		Marie			Angeline		Tuoti			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
no			044 01 0984			Wife Camille			same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) 4167			Coronary Insufficiency Acute.											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			Sudden											
(b)			Cardio Vascular Disease.											
DUE TO, OR AS A CONSEQUENCE OF			Years											
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
+101														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			JOHN G. BALL									CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Burial 9-17-68			23c. NAME OF CEMETERY OR CREMATORIAL Bucks Hill Cem.			23d. LOCATION (City or Town) Waterbury, Conn. (County) (State)					
24. FUNERAL DIRECTOR John J. Murphy			ADDRESS 7552 Hickman Ave Bethesda, Md.			25a. REC'D BY REGISTRAR SEP 18 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

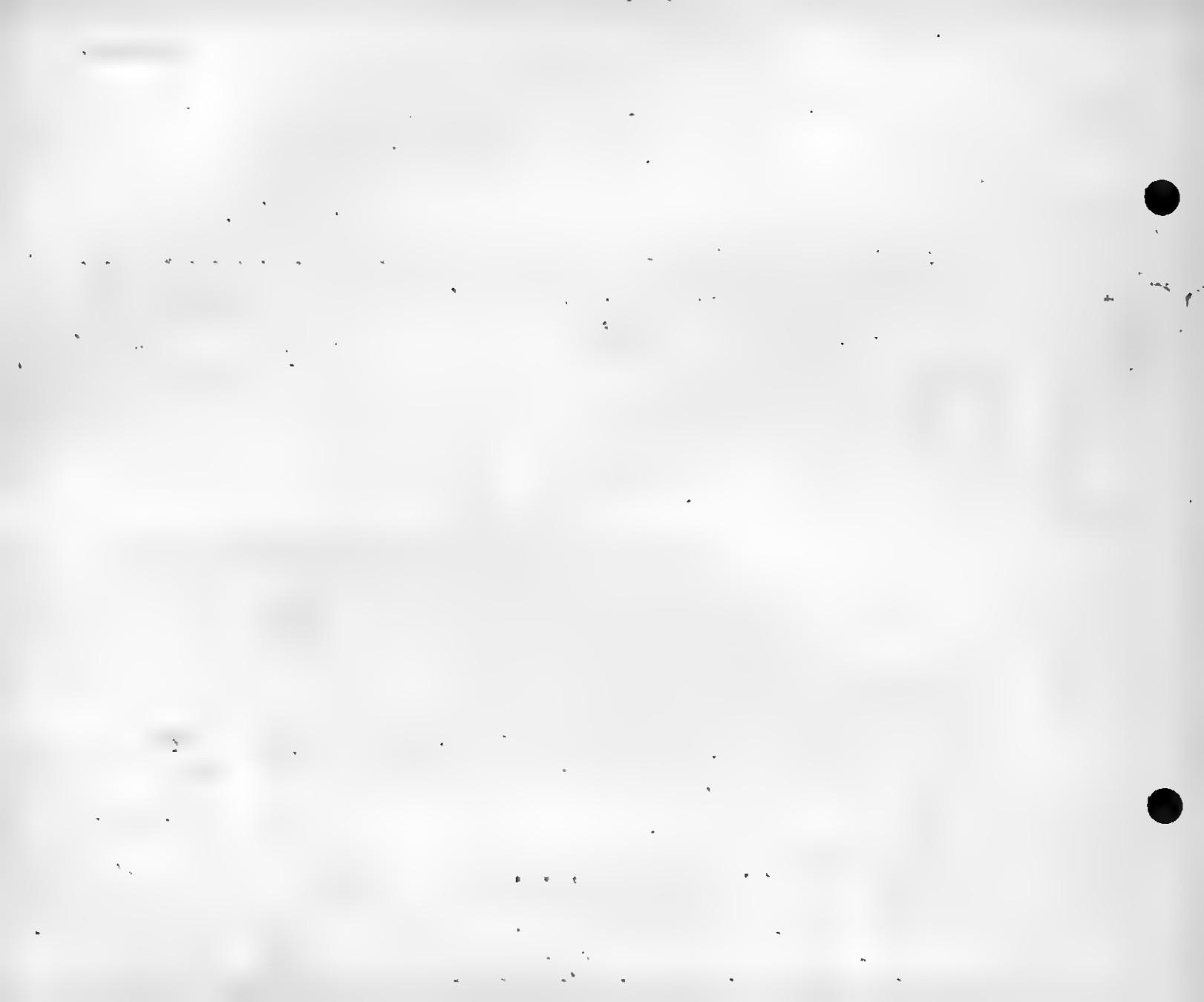
13095

13107

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>KATHERINE</i>	Middle <i>B.</i>	Last <i>CLARK</i>	2a. DATE OF DEATH Month <i>9</i>	Year <i>68</i>	2b HOUR <i>12:33 PM</i>			
3 SEX <i>Female</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>MAY 23, 1891</i>	6 AGE (In years last birthday) <i>77</i>	7 IF UNDER 1 YEAR MONTHS <i>0</i>			8 IF UNDER 24 HRS MONTHS <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	7b CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>MONTGOMERY</i>						
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>ALTHEA WOODLAND</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Sup. of Doc. 20-9-10</i>	12b KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't</i>						
13a. JSUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>	13b. COUNTY <i>MONTGOMERY</i>	13c. CITY OR TOWN <i>Silver Spr. MD</i>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>9331 CAROLINE AVE</i>					
14 FATHER'S NAME First <i>unknown</i>	Middle <i>Fairall</i>	Last <i>Unknown</i>	15. MOTHER'S MA DEN NAME First Middle <i>MARY</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	16b. SOCIAL SECURITY NO. <i>42-578-10-5435-B</i>	17 INFORMANT <i>CHARLES CLARK (SON)</i>	Address <i>1714 Caly Dr. Silver Spring, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Renal Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Carcinoma Breast E</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Metastases</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1714</i>									
19a. DATE OF OPERATION <i>17/6/68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. <i>1714</i>	City or Town <i>Silver Spring</i>	County <i>Montgomery</i>	State <i>Md.</i>				
22a. I certify that (I) (this hospital) attended the deceased from <i>9-6-68</i> to <i>9-6-68</i> , that (I) (we) last saw the deceased alive on <i>9-6-68</i> , and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b. SIGNATURE <i>Bernard A. Fitzgerald, M.D.</i>			
22d. PHYSICIAN'S NAME (Type) <i>Bernard A. Fitzgerald, M.D.</i>	22e. ADDRESS <i>217 Union Blvd E, Silver Spring, Md.</i>	22c. DATE SIGNED <i>9-6-68</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Sept. 9, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Gate of Heaven Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Mont. Md.</i>						
24. FUNERAL DIRECTOR <i>M. Andrew Dwall</i>	ADDRESS <i>Warren E. Pumphrey Inc. 8434 Ga. Ave. S.S., Md.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13096

13108

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)			First <i>Robert</i>	Middle <i>Michael</i>	Last <i>Clarke</i>	2a. DATE OF DEATH <i>September 28, 1968</i>	2b. HOUR M
3. SEX <i>Male</i>		4. RACE <i>White</i>	5. DATE OF BIRTH <i>12-31-94</i>		6. AGE (In years last birthday) <i>73</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital we street address) <i>Washington San & Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Auto salesman</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Auto Company</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Pr. Geo.</i>	13c. CITY OR TOWN <i>Hyattsville</i>	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>2713 Nicholson Street</i>		
14. FATHER'S NAME First <i>Robert</i>		Middle <i>M.</i>	Last <i>Clarke</i>	15. MOTHER'S MAIDEN NAME First <i>Julia</i>		Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-24-0915A</i>		17. INFORMANT <i>Julia E. Clarke</i>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary edema</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Emphysema</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>47 dx</i>		DUE TO, OR AS A CONSEQUENCE OF (c)		<i>5 yrs</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>5-71</i>							
19a. DATE OF OPERATION <i>5-71</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>12/16/68</i> , 19_____, to <i>9/26/68</i> , 19_____, that (I) (we) last saw the deceased alive on <i>9/25/68</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Patrick C. Jameson</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9/26/68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>11718 Georgia Silver Spring Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-28-68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City or Town) <i>Montgomery Co., Md.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Walter E. Humphrey, Inc. 8434 Ga Ave. Silver Spring</i>		ADDRESS <i>Maryland</i>		25a. REC'D BY REGISTRAR <i>DA SEP 30 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13097

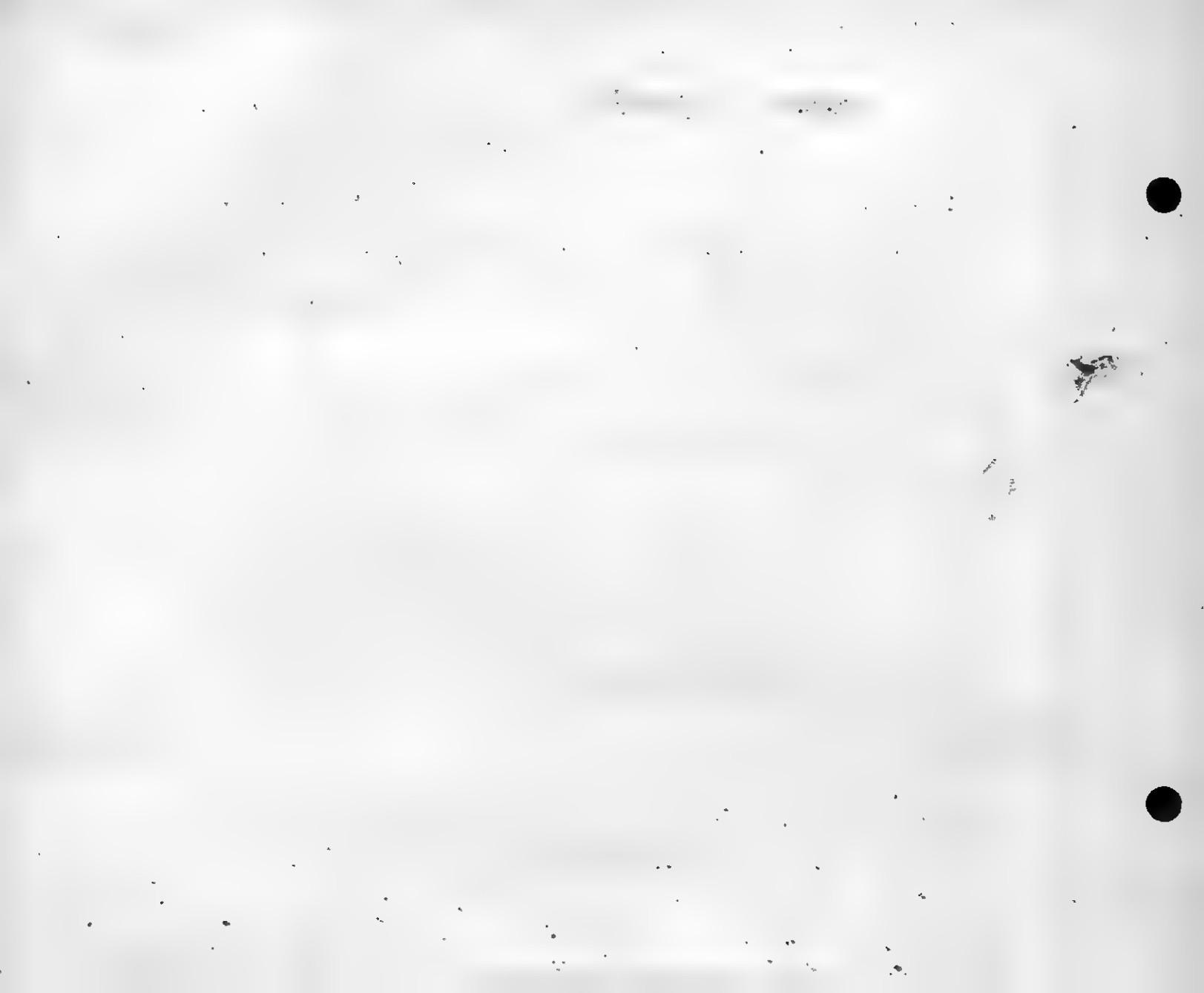
13109

HELEN LOUTSE CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First [REDACTED]	Middle [REDACTED]	Last Clouse	2d. DATE OF DEATH Month 9 Day 25 Year 68	2b. HOUR 400 M
3 SEX Female	4 RACE white	5 DATE OF BIRTH 12-30-1908	6 AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) Indiana	7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BethesdaWoodland Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Government administrative officer	12b. KIND OF BUSINESS OR INDUSTRY government		
13c. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 609 Ray Drive	
14. FATHER'S NAME First John	Middle Clouse	15. MOTHER'S MAIDEN NAME First	Middle	Lost	Beatty
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO	17. INFORMANT Mrs. Cassandra Sinclair Fairman, Md	Address	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myelocytic Leukemia</u>					
2051 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause just.					
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2041					
19c. MEDICAL CERTIFICATION	19d. DATE OF OPERATION	19e. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased <u>Helen Loutse</u> , April 19, 1968, to Sept. 19, 1968, that (I) (we) last saw the deceased alive on <u>Sept 25 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bernard A. Fitzgerald	DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9-25-68
22d. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD	22e. ADDRESS 217 Lansdowne Blv E, Silver Spring Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL (Specify)	23b. DATE Sept 28-1968	23c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery	23d. LOCATION (City or Town) Washington DC	(County)	(State)
24. FUNERAL DIRECTOR Ferdinand Walters	254 Rockville Rd, Bethesda, MD 20817	ADDRESS	250. REG'D BY REGISTRAR Date SEP 27 1968	25b. REG'ISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13110

13098

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First FRANK	Middle NMN	Last COATES	2a. DATE OF DEATH Month 9	Day 11	Year 68	2b. HOUR & 10 P	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 3-21-19			6. AGE (In years last birthday) 49	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN 0
7a. BIRTHPLACE (State or foreign country) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? United States	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer			12b. KIND OF BUSINESS OR INDUSTRY c/p Sadie Budd	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Sandy Spring	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 18462 Brooke Road				
14. FATHER'S NAME First unknown	Middle 	Last 	15. MOTHER'S MAIDEN NAME First unknown	Middle 	Last 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 	17. INFORMANT Admission Recd, Montgomery General, Olney, Md			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vaccinia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 582X (b) Nephritis, chronic DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 592X					15 yrs			
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) 	21f. LOCATION Street or R.F.D. No 	City or Town 		County 	State 	
22o. I certify that (I) (this hospital) attended the deceased from Aug 20, 1968 , to Sept 11, 1968 , that (I) (we) last saw the deceased alive on Sept 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE A. D. Bonifas		DEGREE 	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 		
22d. PHYSICIAN'S NAME (Type) A. D. Bonifas		22e. ADDRESS Sandy Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9-14-68	23c. NAME OF CEMETERY OR CREMATORIUM ASH MEMORIAL CEM.	23d. LOCATION (City or Town) (County) SANDY SPRING, MONTG. MD				
24. FUNERAL DIRECTOR George R. Schowden		ADDRESS Rockville Dr.	25a. REC'D BY REGISTRAR DATE SEP 17 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A134 30M REV 7/68								



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

130911

13111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death.**PAGE 4** may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
M. VIRGINIA CLEVELAND Cockerille				September 24 1968	
3. SEX	4. RACE		5. DATE OF BIRTH	6. AGE (in years last birthday) 85 yrs.	
FEMALE	WHITE		August 9 1883		
7a. BIRTHPLACE (State or foreign country) D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH - Montgomery	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) OLNEY MARYLAND		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) GOVT.	12b. KIND OF BUSINESS OR INDUSTRY GOVT.	
13a. US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WASH. D.C.	13b. COUNTY WASH. D.C.	13c. CITY OR TOWN WASH. D.C.	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1521 BEAUNDYWINE ST. N.W.	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	
Samuel J Cockerille.				Deborah Siford	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 579-62-4655		17. INFORMANT Patient about.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 485 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 485 Congestive heart failure					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 11-8, 1968 to 9-24, 1968, that (I) (we) last saw the deceased alive on 9-24 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John R. Spencer MD	DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9-24-68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS BURTONSVILLE, MD.				
23c. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 9/24/68	23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cem	23d. LOCATION (City or Town) Wash D.C.	(County)	(State)
24. FUNERAL DIRECTOR C. K. HOGSTEDT MAINIV	ADDRESS 5732 La line	25a. RECD BY REGISTRAR DATE SEP 30 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13100

13112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 4 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <i>Thomas</i>	Middle <i>Bradley</i>	Last <i>Colburn</i>	2a. DATE OF DEATH Month <i>Sept</i>	Day <i>20</i>	Year <i>1968</i>	2b. HOUR <i>12:00 M</i>	
3 SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>3/15/93</i>		6. AGE (in years last birthday) <i>75</i>		7. IF UNDER 1 YEAR MONTHS <i>0</i>		8. IF UNDER 24 HRS. HOURS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Laundryman retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Laundry</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Wash. D.C.</i>		13c. CITY OR TOWN <i>Wash. D.C.</i>		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>6615 675 St. NW</i>			
14. FATHER'S NAME First <i>Winfred Scott</i>		Middle <i>Colburn</i>	Last <i>Ella</i>	15. MOTHER'S MAIDEN NAME First <i>Ella</i>		Middle <i>Ed</i>	Last <i>Birch</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>578-05-9479</i>		17. INFORMANT <i>4719-Nantucket Address - City Park -</i>		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4109</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Occlusion</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis</i>				<i>+8 hrs.</i>	
								<i>10 years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Abdominal Aortic Aneurysm</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 1967</i> , 1967, to <i>Sept 20 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 19 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Glen D. Herman</i>		22c. DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED <i>Sept 20 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>John D. Herman</i>		22e. ADDRESS <i>4801 Montgomery Ln, Bethesda, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-23-1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek Cemetery</i>		23d. LOCATION (City or Town) <i>Washington, D. C.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>M. Andrew Duvall</i>		ADDRESS <i>Warren E. Humphrey, Inc. 8434 Ga Ave. Silver Spring, Md.</i>		25a. RECD BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>SEP 25 1968</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13103

CERTIFICATE OF DEATH

13113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me, please remove carbon copies, page 13103 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First MATTIE	Middle Collins	Lost	2a. DATE OF DEATH 9 Month 4 Day '68 2:00 PM	2b. HOUR 2:00 PM
3. SEX F	4. RACE Negro	S. DATE OF BIRTH 12-25-1875	6. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) TEXAS	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	12b. KIND OF BUSINESS OR INDUSTRY None	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Hos. Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	13c. CITY OR TOWN Washington, DC	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 3405 Mass. Ave. S.E.
14. FATHER'S NAME First None	Middle NO	Lost	15. MOTHER'S MAIDEN NAME First Erma J. Morgan	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. None	17. INFORMANT Erma J. Morgan	Address 3405 Mass. Ave. S.E.		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 L.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF unknown Pneumonia					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 L.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 8/3/68 , to 9/4/68 , that (I) (we) lost saw the deceased alive on 3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ralph Jones MD	DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9/4/68
22d. PHYSICIAN'S NAME (Type) Ralph Jones MD	22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-9-68	23c. NAME OF CEMETERY OR CREMATORIAL Church Cemetery	23d. LOCATION (City or Town) Waco, Texas	(County)	(State)
24. FUNERAL DIRECTOR John T. Rhineco	ADDRESS 3015-12, ch. 716 Wash. D.C.	25a. REC'D BY REGISTRAR DATE SEP 9 1968	25b. REGISTRAR'S SIGNATURE J Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2a & 2b
13102 13114

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

1. DECEASED NAME (Type or print)		First JOHN A CONDON	Middle	Last	2a. DATE OF DEATH Month 9 Day 12 Year 68	2b. HOUR M	
3. SEX MALE		4. RACE WHITE	5. DATE OF BIRTH 4/27/16		6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) N. YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN Hosp Representative		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Businessman		12b. KIND OF BUSINESS OR INDUSTRY Businessman	
13a. USUAL RESIDENCE (Where deceased admission) STATE WASH. DC		13b. COUNTY WASH. DC		13c. CITY OR TOWN WASH. DC	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3212 Chestnut St NW	
14. FATHER'S NAME First JOHN		Middle Condon	Last	15. MOTHER'S MAIDEN NAME First Caroline		Middle	Last Cassidy
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes WW II 1941 - 1945		16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Chester J. Hildreth - 13019 Baltimore St		Address Bethesda, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 150 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS CONSEQUENCE OF (b) Carcinoma of the Trachea		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 days			
		DUE TO, OR AS CONSEQUENCE OF (c) Carcinoma of the Esophagus				90 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 151 Mega esophagus							
19a. DATE OF OPERATION 9/10/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory Distress		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Aug 23, 1968 to Sept. 12 1968 , that (I) (we) last saw the deceased alive on Sept 12 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did-not) view the body after death.							
22b. SIGNATURE John D. Herman MD		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 9/13/68		
22d. PHYSICIAN'S NAME (Type) 		22e. ADDRESS 					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-17-68	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Wheaton Md.		
24. FUNERAL DIRECTOR W.W. Chambers Co.		ADDRESS 1400 Clarendon St. N.W. Wash. D.C.	25a. REC'D BY REGISTRAR DATE SEP 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13102

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13115

1 DECEASED NAME (Type or Print)	First Middle Last			2a DATE KNOWN <input type="checkbox"/> Month Day Year of ESTI DEATH MATED <input checked="" type="checkbox"/> Sept 28 1968 168 7:00 M	2b HOUR M		
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>8/6/68</i>	6 AGE (in years last birthday) <i>1 yr 22 days</i>	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	8c DATE PRONOUNCED DEAD Month Day Year <i>Sept 28 1968</i>	2d HOUR M	
7a BIRTHPLACE (State or foreign country) <i>New Jersey</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>	10. CITY OR TOWN OF DEATH <i>Bethesda</i>			
11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) <i>Suburban</i>				12a USUAL OCCUPATION AND OF WORK DONE during most of working life, even if retired) <i>Infant</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>N.J.</i>		13b COUNTY <i>Cumberland</i>	13c CITY OR TOWN <i>Cumberland</i>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>522 Elmwood St</i>	12b KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME First <i>Lawrence</i>	Middle <i>Cook</i>	Last <i>John</i>	15 MOTHER'S MAIDEN NAME First <i>Caren</i>	Middle <i>Selma</i>	Last <i>Selma</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b SOCIA. SECURITY NO (If yes give war or dates of service) <i>—</i>	17 INFORMANT <i>Father</i>	ADDRESS <i>Same as 13c</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Anoxic from Pulmonary Edema.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
(b) <i>Viral Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF <i>lost</i>				48 hr.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>+72 X</i>							
19a DATE OF OPERATION <i>7-12 X</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>WHILE AT WORK</i>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1b)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>—</i>	21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John G. Bell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>—</i>			22b DATE SIGNED <i>Sept 28, 1968</i>		
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE <i>Oct 1, 1968</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Pine Grove Cemetery</i>	23d LOCATION (City or Town) <i>Mt. Airy</i>	(County) <i>Carroll</i>	(State) <i>Md.</i>		
24 FUNERAL DIRECTOR <i>John E Goff</i>	ADDRESS <i>Hampstead, Maryland</i>	25a REC'D BY REGISTRAR DATE <i>OCT 2 1968</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13106

CERTIFICATE OF DEATH

13116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR Year
Eunice C. Cooper				9 - 28 - 1968	6:45 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
FEMALE	White	10-30-1885		82	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	
CHINA	U.S.A.			Montgomery	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Bethesda	Dr. Andrew Lane Nursing Home			NURSE	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
D.C.	-	WASHINGTON	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4111 GARRISON ST. N.W.	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	Address
JOHN PHELPS COWLES				SIGOURNEY TRESS WASH., D.C.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO	-	WILLIAM C. DELACY, 413 WOODWARD BLDG.,	3 wks		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 5111 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) TOXIC Gastro Enteritis					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 571.1					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from July 19, 1968, to Sept 20, 1968, that (I) (we) last saw the deceased alive on Sept 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Lockett MD	DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9/29/68
22d. PHYSICIAN'S NAME (Type) R. Wm. Lockett	22e. ADDRESS		5000 Reno Road N.W., WASH., D.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-1-1968	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town) Ipswich, Mass.	(County)	(State)
24. FUNERAL DIRECTOR Joseph Fowler's Sons, Inc., 5130 Wisconsin Ave. N.W., Wash., D.C., 20016	ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 2 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13105

13117

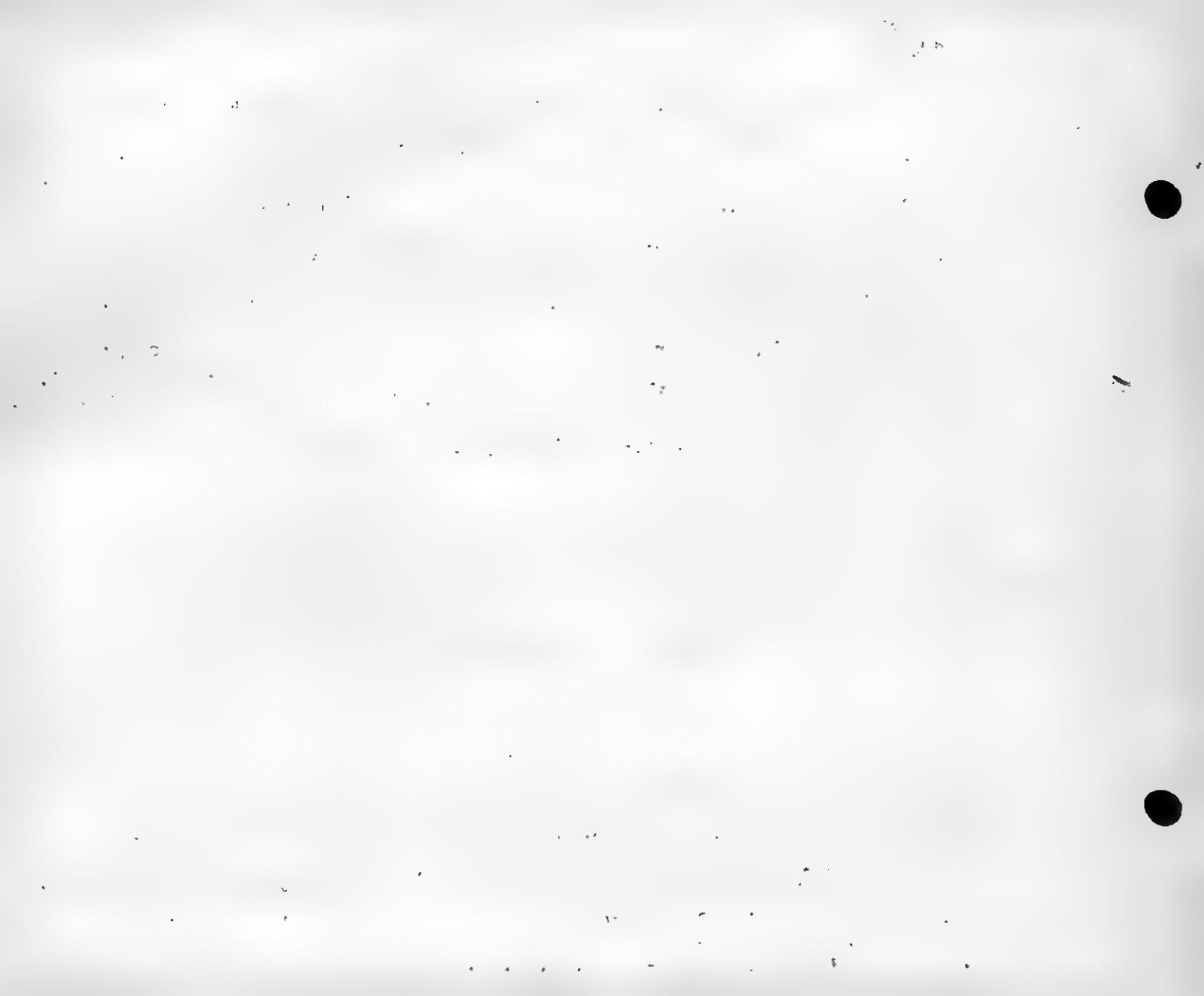
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)	First Elizabeth	Middle Ann	Lost Cranston	2a. DATE OF DEATH Month Sept	2b. HOUR P.M. 3:15			
3. SEX Female	4 RACE CAU	5. DATE OF BIRTH 21 SEPTEMBER 1968		6. AGE (In years last birthday) YRS. 0 0	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 1	HOURS 8	MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA.	B MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NA		12b. KIND OF BUSINESS OR INDUSTRY NA			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia	13b. COUNTY Falls Church	13c. CITY OR TOWN Falls Church	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2212 Mohegan Drive.				
14. FATHER'S NAME James	First R.	Middle Cranston	15. MOTHER'S MAIDEN NAME Claudette	16. Middle (N)	17. Last Samoreault			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Years or unknown 20	16b. SOCIAL SECURITY NO NA	17. INFORMANT James R. Cranston, Falls, Church, Va.	Address 2212 Mohegan Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anemia, Etiology undetermined 1187 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) lost (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (s) (this hospital) attended the deceased from Sept 21, 1968, to 21 Sept, 1968, that (s) (we) last saw the deceased alive on September 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) <input type="checkbox"/> view the body after death.								
22b. SIGNATURE J.G. Fleming		M.D. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 23 SEPT 1968		
22d. PHYSICIAN'S NAME (Type) J.G. FLEMING		22e. ADDRESS Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE Sept 24, 1968	23c. NAME OF CEMETERY OR CREMATORIUM St. Johns	23d. LOCATION (City or Town) Forest Glen, Md.	(County)	(State)		
24. FUNERAL DIRECTOR TALTAVULL FUNERAL HOME		ADDRESS 3603 14St. NW. W.D.C.		25a. REC'D BY REGISTRAR DATE SEP 25 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 30M REV 1968								



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13106

13118

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Rosa</i>	Middle <i>E</i>	Last <i>Crilly</i>	2a. DATE OF DEATH Month <i>Sept</i>	Day <i>11</i>	Year <i>1968</i>	2b. HOUR <i>9:00 AM</i>			
3. SEX <i>Female</i>	4 RACE <i>white</i>	5. DATE OF BIRTH <i>3/7/90</i>		6. AGE (In years last birthday) <i>78</i>	YRS.	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	2b. HOUR HOURS <i>0</i>	2b. HOUR MIN. <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>							
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Post</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>5610 Springfield Dr.</i>						
14. FATHER'S NAME First <i>John</i>	Middle <i>Crilly</i>	Last <i>Margaret</i>	15. MOTHER'S MAIDEN NAME First <i>Carroll</i>	Middle <i></i>	Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>	16b. SOCIAL SECURITY NO. <i>W.41-N-597-34-9569</i>	17. INFORMANT <i>513700</i>	Address <i>East Crilly Street Above</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Confluent bronchopneumonia, bilateral (Klebsiella)</u> 485X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic debilitated state</u> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 491X										
19a. DATE OF OPERATION <i>4/11/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State		
22a. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>1960</u> , to <u>9/11</u> , <u>1968</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>9/10</u> <u>1968</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (<u>did not</u>) view the body after death.										
22b. SIGNATURE <i>J. Blaine Fitzgerald</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9/11/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>J. Blaine Fitzgerald, M.D.</i>		22e. ADDRESS <i>8218 Wisc. Ave., Bethesda, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-14-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mount Olivet Cemetery</i>		23d. LOCATION (City or Town) <i>Washington, D.C.</i>		(County)		(State)	
24. FUNERAL DIRECTOR <i>Les Gavleis Sons Wash. D.C.</i>		ADDRESS		25a. REGD. BY REGISTRAR <i>SEP 10 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Gavleis</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13107

CERTIFICATE OF DEATH

13119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Baby Boy</i>	Middle <i>Crown</i>	Last	20. DATE OF DEATH Month 9 Day 17 Year 68	26. HOUR 6:30 PM			
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>9-17-68</i>		6. AGE (In years lost birthday) YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Marygomery</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda, Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Suburban</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Marygomery</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>1001 E. Marygomery Ave.</i>				
14. FATHER'S NAME First <i></i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Grace</i>	Middle <i>Ellen</i>	Last <i>Crown</i>	Address		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i></i>	17. INFORMANT <i>Birth Certificate</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Immaturity</i> 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i></i> (b) DUE TO, OR AS A CONSEQUENCE OF lost (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) --								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Sep 17, 1968</i> , to <i>Sep 17, 1968</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Ivan Nyirjesy</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Sep 19, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>IVAN NYIRJESY</i>		22e. ADDRESS <i>8218 Wisconsin Ave. Bethesda - Mont. Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>9/18/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Suburban Hospital</i>	23d. LOCATION (City or Town) <i>Bethesda - Montg. MD.</i>	(County)	(State)			
24. FUNERAL DIRECTOR <i>Mrs. Andria Carter - Administrator EA</i>	ADDRESS <i></i>	"	25a. REC'D BY REGISTRAR DATE <i>SEP 25 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

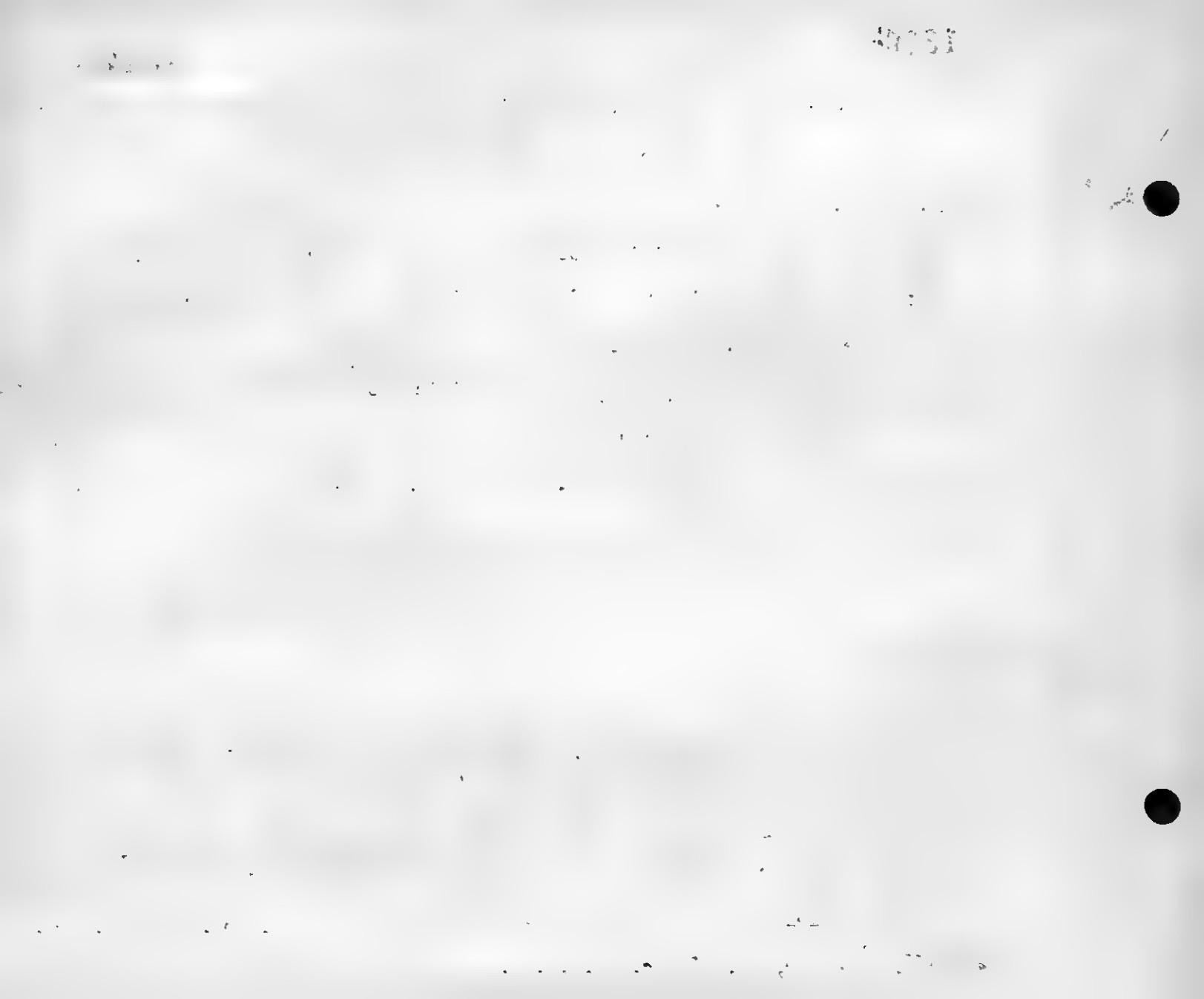
CERTIFICATE OF DEATH

13103

13120

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the attending physician or funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Then file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First Michael	Middle James	Last Cullinane	2a DATE OF DEATH Month September	Day 3	Year 1968	2b HOUR 10:50
3 SEX Male	4. RACE White	5 DATE OF BIRTH 24 November 1948		6 AGE (in years lost birthday) 19	7 MONTHS 0	8 DAYS 0	9 HOURS 0	10 MIN. 0
7a BIRTHPLACE (State or foreign country) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b KIND OF BUSINESS OR INDUSTRY Hospital School			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMIT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 10417 Huntley Avenue				
14 FATHER'S NAME First Roger	Middle J. Cullinane	Last	15 MOTHER'S MAIDEN NAME First Loretta	Middle	Last McGraw			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> no, or unknown No	16b. SOCIAL SECURITY NO. 577-64-2591	17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hodgkin's Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Years		
DUE TO, OR AS A CONSEQUENCE OF (b) Lobar Pneumonia (left lower lobe)						days ?		
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) None								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>If either, notify medical examiner</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 24 July , 19 68 , to 3 Sept. , 19 68 , that <input type="checkbox"/> (we) last saw the deceased alive on 3 September 1968 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.								
22b. SIGNATURE John J. Senyszyn MD		DEGREE MD	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 4 September 1968		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-7-1968	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery		23d. LOCATION (City or Town) Sil. San. Monta. Md.	(County)	(State)	
24. GENERAL DIRECTOR Valerie E. Pampfrey		ADDRESS Valerie E. Pampfrey, Inc. 8434 Ge. Ave. S.S. Md.	25a. REC'D BY REGISTRAR SEP 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 from the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

13109

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13121

1. DECEASED-NAME (Type or print)	First Con	Middle Brady	Last Curry Jr.	2a. DATE OF DEATH Month September Day 19 Year 1968	2b. HOUR A 7:50 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 25 March 1923		6. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS M N
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) General Manager	12b. KIND OF BUSINESS OR INDUSTRY Insurance		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Ohio	13c. CITY OR TOWN Englewood	13d. INSIDE CITY LIMIT YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6617 Templehurst Road		
14. FATHER'S NAME Con	First Brady	Middle Curry Sr.	15. MOTHER'S MAIDEN NAME Media	Middle White	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 1942-1945	17. INFORMANT The Medical Record The Clinical Center, NIH, Bethesda, Md. 20014	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 2051 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause DUE TO, OR AS A CONSEQUENCE OF Pulmonary hemorrhage (b) DUE TO, OR AS A CONSEQUENCE OF Chronic myelogenous leukemia (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 21. MEDICAL CERTIFICATION 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					28 hours 3½ years
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 17 Sep 1968, to 19 Sep 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 19 Sep 1968, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE Clarence H. Brown, III, M. D.	DEGREE ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 19 September 1968	
22d. PHYSICIAN'S NAME (Type) Clarence H. Brown, III, M. D.	22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014				
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Transit	23b. DATE 9/23/68	23c. NAME OF CEMETERY OR CREMATORIAL Rockville Pike	23d. LOCATION (City or Town) Dayton, Ohio	(County)	(State)
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.	ADDRESS Rockville, Md.	25a. REC'D BY REGISTRAR DATE SEP 23 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

1133

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13110

13122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First EDWARD	Middle Wilhelm	Last DAVIS	2a. DATE OF DEATH Month Sept	Day 3	Year 1968	2b. HOUR 15				
3. SEX Male	4 RACE W	S. DATE OF BIRTH 9/12/13	5. AGE (in years lost birthday) 54	6. IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0				
7a. BIRTHPLACE (State or foreign country) West Va	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery								
10. CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital	12a USUAL OCCUPATION (Kind of work done during most all working life, even if retired) Housewife	12b KIND OF BUSINESS OR INDUSTRY Always Busy								
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Mont.	13c CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 4409 Independence St.							
14. FATHER'S NAME First Edward	Middle W	Last Davis Jr	15. MOTHER'S MAIDEN NAME First Effie	Middle Stowasser	Last 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 577-09-2078	17 INFORMANT Mrs. Anna M. Davis 4414 Independence St. Rock	Address								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, right upper lobe, lung with widespread metastasis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. 10 Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from 8-21, 1968 , to 9-3, 1968 , that (I) (we) last saw the deceased alive on 9-3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE J.H. Mish M.D.								22c. DATE SIGNED 9-3-68			
22d. PHYSICIAN'S NAME (Type) J.K. Hammond Mish M.D.				22e. ADDRESS 3800 JENIFER ST. N.W. WASH. D.C. 20015							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 6, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City or Town) Parkville		(County) Montgomery		(State) Maryland		
24. FUNERAL DIRECTOR M. Andrew Duvall		ADDRESS Warner E. Pumphrey Inc. 8434 Georgia Ave. N.E.	25a. REC'D BY REGISTRAR DA SEP 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						



13112

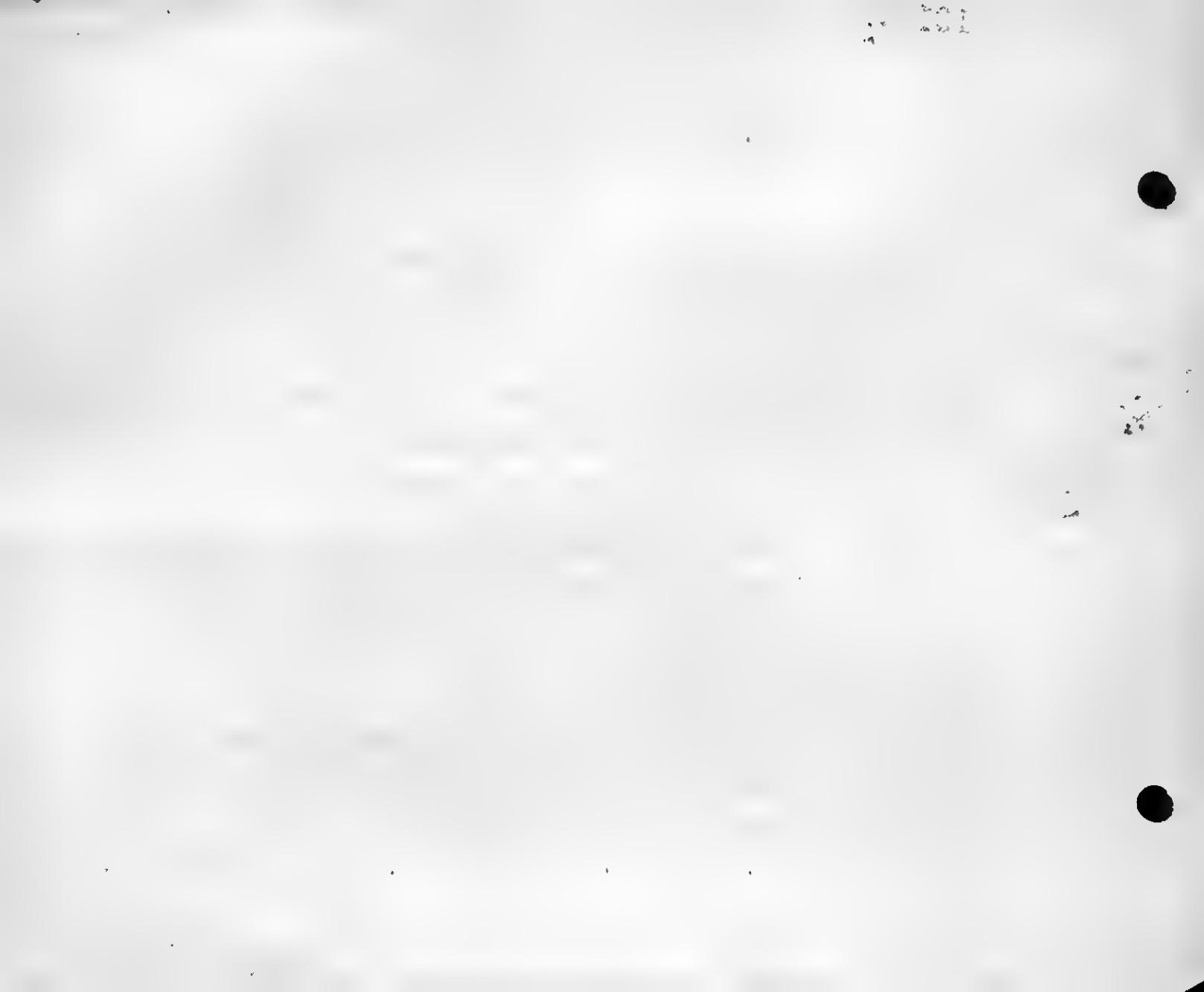
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13123

Items#7a,b, FilmG405 10/7/68 km CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-intrust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH 9 25 Year 68	2b. HOUR 26. HOUR
Genest		Davis			
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 2/2/1900		6. AGE (in years last birthday) 68 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 COUNTY OF DEATH Montgomery	Md
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Farmworkers			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Private	12b KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 114 3	
14. FATHER'S NAME Richard T. Jones	First	Middle	Last	15. MOTHER'S MIDDLE NAME Alice	Address 331 Lincoln Rd. Bethesda, Md.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 215-44-1231	17 INFORMANT W. William Johnson Lincoln Rd. Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditons, if any, which gave rise to immediate cause (a). stating the underlying cause last. 5371 (b) pulmonary edema and emphysema DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Right ventricular myocardial hypertrophy					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Sept 21, 1968, to Sept 25, 1968, that (I) (we) last saw the deceased alive on Sept 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Nichel M. Healy, M.D.	ATTENDING DEGREE PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9/26/68	
22d. PHYSICIAN'S NAME (Type) NICHEL M. HEALY, M.D.	22e. ADDRESS Suite 205A 5411 W. Cedar Lane Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-28-68	23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park Cem.	23d. LOCATION (City or Town) Rockville	(County) Montgomery	(State) Md
24. FUNERAL DIRECTOR Robert L. Snowdon Rockville, Md.	ADDRESS	25a. REC'D BY REGISTRAR OCT 1 1968		25b. REGISTRAR'S SIGNATURE Charles J. George	



MARYLAND STATE DEPARTMENT OF HEALTH

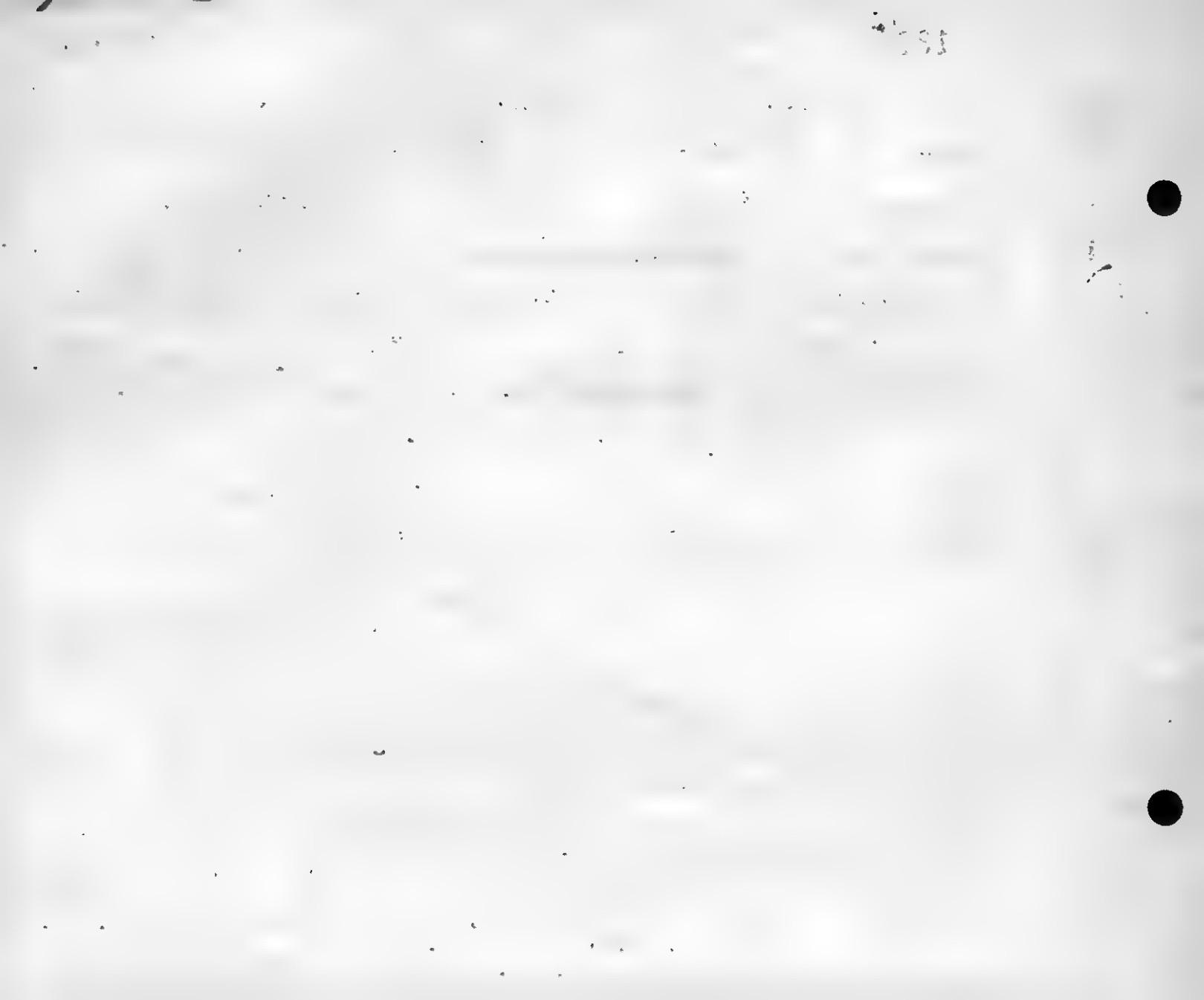
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove, sign on back, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First <i>Joseph</i>	Middle <i></i>	Last <i>Deebo</i>	2. DATE OF DEATH Month <i>9</i>	Doy <i>16</i>	Year <i>1968</i>	2b. HOUR <i>7:45 AM</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>4-17-1881</i>			6. AGE (In years last birthday) <i>87 yrs.</i>	IF UNDER 1 YEAR MONTHS <i></i>	IF UNDER 24 HRS DAYS <i></i>
7a. BIRTHPLACE (State or foreign country) <i>Syria</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>MONTGOMERY</i>			10. CITY OR TOWN OF DEATH <i>KENSINGTON</i>	
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kensington Gardens SAH</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Self Employed</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>MONTGOMERY</i>	13c. CITY OR TOWN <i>Glen Echo</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>#1 VASSAR CIRCLE</i>			
14. FATHER'S NAME First <i>George</i>	Middle <i>Deebo</i>	15. MOTHER'S MAIDEN NAME First <i>Hilda</i>	Middle <i></i>			Last <i>(Unknown)</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>220 32 7150</i>	17. INFORMANT <i>Mr. John Deebo, Glen Echo, Md. 20768</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>INSTANT</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>DIABETES MELLITUS</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1968</i> , to <i>Dec 1968</i> , that (I) (we) last saw the deceased alive on <i>9/17/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. J. Donovan</i>		DEGREE <i>DR. J. J. DONOVAN</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>9/16/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>DR. J. J. DONOVAN</i>	22e. ADDRESS <i>4217 WISCONSIN AVN BETHESDA MARYLAND 20014</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9/18/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>			23d. LOCATION (City or Town) <i>Rockville, Montg. Md.</i>	(County) <i></i>	(State) <i></i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUIPHREY, Bethesda, Md.</i>	7557 ADDRESS <i>WISCONSIN AVN</i>			25a. REC'D BY REGISTRAR <i></i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



1311

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13125

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 11:15 AM
<i>Anna M. Deese</i>						Sept	18	1968	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>3/1/97</i>		6 AGE (in years last birthday) <i>71</i>		7f. UNDER 1 YEAR MONTHS	
								DAYS	HOURS MN
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased admission) STATE <i>Md</i>		13b CITY OR TOWN <i>Mont</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>601 Anderson Ave</i>	
14. FATHER'S NAME <i>Lewis W. Cochran</i>				15 MOTHER'S MAIDEN NAME <i>Sarah Lewis</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No, no, or unknown</i>		16b. SOCIAL SECURITY NO. <i>577 05 3622A</i>		17 INFORMANT <i>Mabel Cartwright sister - same # 13</i>		Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Peritonitis, suppurative, extensive</i></p> <p>X DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost</p> <p>(b) <i>necrotic perforation of colostomy site</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>									
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p><i>7/1/68</i></p>									
19a. DATE OF OPERATION <i>July 1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Colitis</i>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
<p>22a. I certify that (I) (this hospital) attended the deceased from <i>July 24, 1968</i>, to <i>date</i>, 19<i>68</i>, that (I) (we) last saw the deceased alive on <i>7/1/68</i> 19<i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE <i>A.F. Castro M.D.</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>7-18-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>A.F. Castro M.D.</i>		22e. ADDRESS <i>916 - 19th St NW</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9/21/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rockville</i>		23d. LOCATION (City or Town) <i>Rockville</i>		(County) (State) <i>Montgomery Md.</i>	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS <i>11 Rock. Pike Rockville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



Divver 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

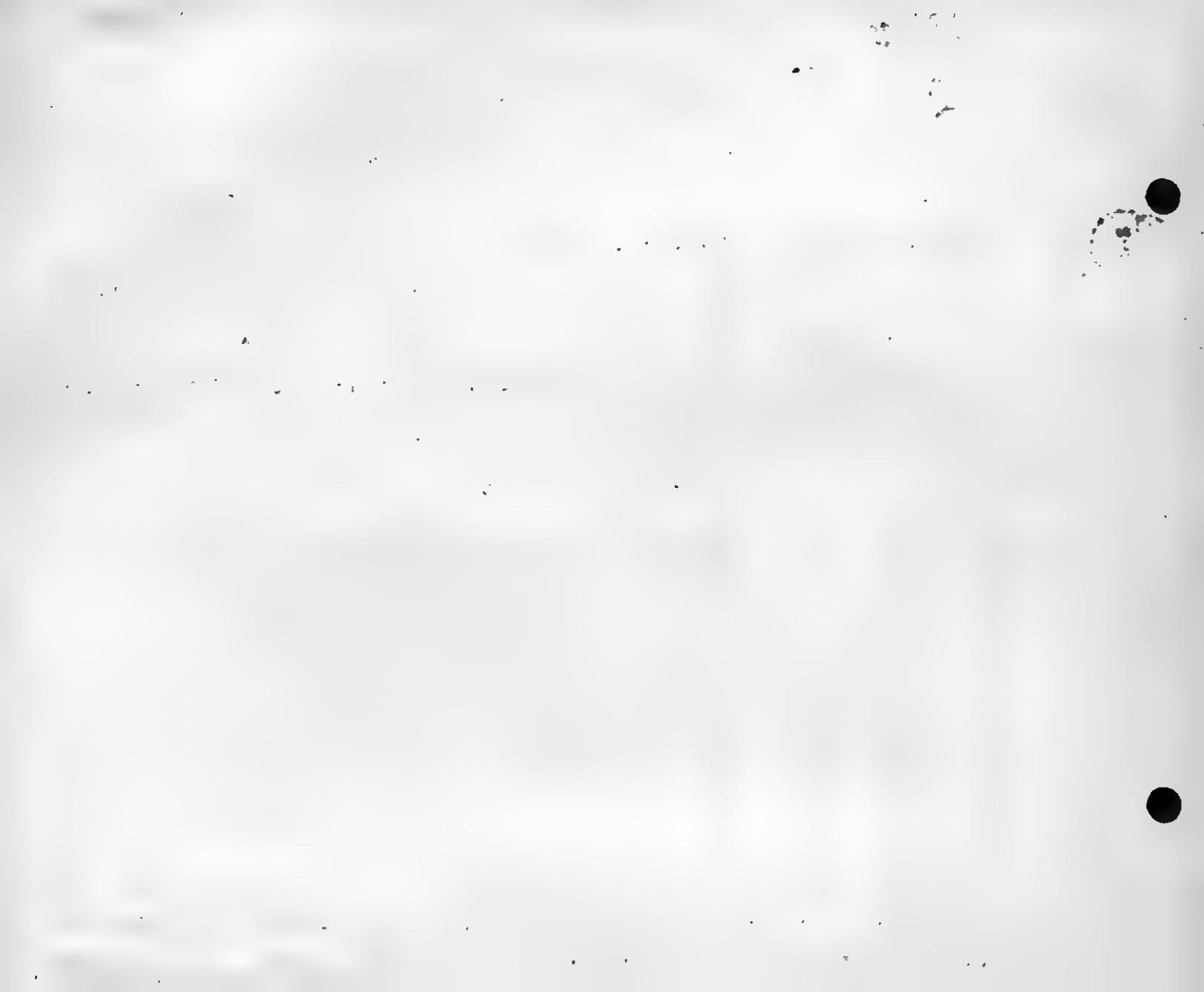
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13114

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13126

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First Baby	Middle Boy	Last Divver	2a. DATE OF DEATH Month Sept. 8, 1968	Day Year 1968	2b. HOUR 6:35 M
3. SEX Male	4 RACE White	5. DATE OF BIRTH September 8, 1968		6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS 1	IF UNDER 24 HRS. HOURS MIN 1
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	Md.		
10. CITY OR TOWN OF DEATH Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital or wash. address) Wash. San & Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.	13b. COUNTY Mont	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMIT YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 12000 Old Georgetown Rd.		
14. FATHER'S NAME First Refused	Middle 	Last 	15. MOTHER'S MAIDEN NAME First Clyde	Middle Lenore	Last Divver	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17 INFORMANT Miss Clyde Divver	Address 12000 Old Georgetown Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac & Respiratory failure 7762 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (26 wks). - 14 oz = WT. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7735						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	9:15 am.
22a. I certify that (I) (this hospital) attended the deceased from 9-8-1968 to 9-8-1968 , that (I) (we) last saw the deceased alive on 9-8-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>J. Chen Yew Ng.</i>	DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	<input checked="" type="checkbox"/>	22c. DATE SIGNED 9-8-68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 9-9-68	23c. NAME OF CEMETERY OR CREMATORIAL Washington San & Hospital	23d. LOCATION (City or Town) Takoma Park, Mont., Md.	(County)	(State)	
24. FUNERAL DIRECTOR J. D. Ruffcorn	ADDRESS 7600 Carroll Ave., TK PK., Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE SEP 11 1968			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13127

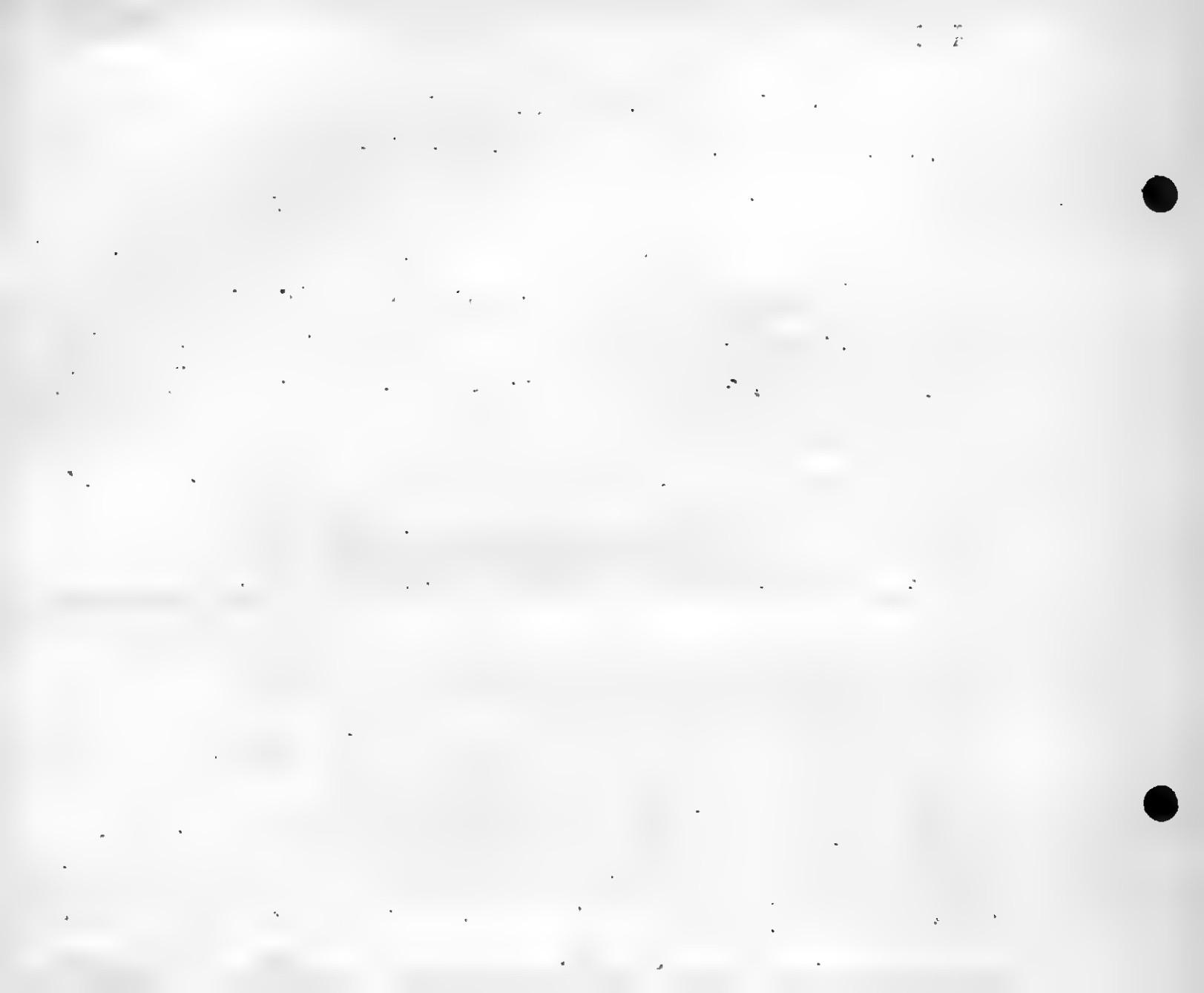
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13115

1. DECEASED NAME (Type or print)	First <u>GUSSIE</u>	Middle <u>B.</u>	Lost <u>DOANE</u>	2a. DATE OF DEATH Month <u>Sept</u> Day <u>12</u> Year <u>1968</u>	2b. HOUR <u>9:30 AM</u>
3. SEX <u>FEMALE</u>	4. RACE <u>WHITE</u>	S. DATE OF BIRTH <u>5-14-93</u>	6. AGE (in years last birthday) <u>75</u> YRS.	F. UNDER 1 YEAR MONTHS <u>0</u>	F. UNDER 24 HRS. DAYS <u>0</u>
7a. BIRTHPLACE (State or foreign country) <u>VA</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <u>MONTGOMERY COUNTY</u>		
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>MD.</u>	13c. CITY OR TOWN <u>MONTGOMERY ROCKVILLE</u>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <u>13801 BAUER DRIVE</u>		
14. FATHER'S NAME First <u>Thomas</u>	Middle <u>BURGESS</u>	15. MOTHER'S MAIDEN NAME First Middle <u>CATHERINE</u>	Last <u>CARTER</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <u>NONE</u>	17. INFORMANT <u>MRS. CHARLES KLEIN - 13801 BAUER DRIVE</u>	Address <u>ROCKVILLE, MD.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>407</u> (b) <u>Cerebral Vascular accident</u> 10K (c) <u>Cerebral Arteriosclerosis</u> 4 yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <u>Diabetes mellitus ASHD, Hypertension</u>					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1962</u> to <u>SEPTEMBER 1968</u> , that (I) (we) last saw the deceased alive on <u>SEPTEMBER 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did-not) view the body after death.					
22b. SIGNATURE <u>Raymond T. Benack</u>	DEGREE <u>MD</u>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>9/12/68</u>
22d. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>	22e. ADDRESS <u>4115 Millie Dr. Wheaton, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 12, 1968</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Pleasant Cemetery</u>	23d. LOCATION (City or Town) <u>Salisbury, Virginia</u>	(County) <u></u>	(State) <u></u>
24. FUNERAL DIRECTOR <u>J. Beckley Green, Herndon, Va.</u>	ADDRESS <u></u>	25a. REC'D BY REGISTRAR <u></u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	DATE <u>SEP 17 1968</u>	

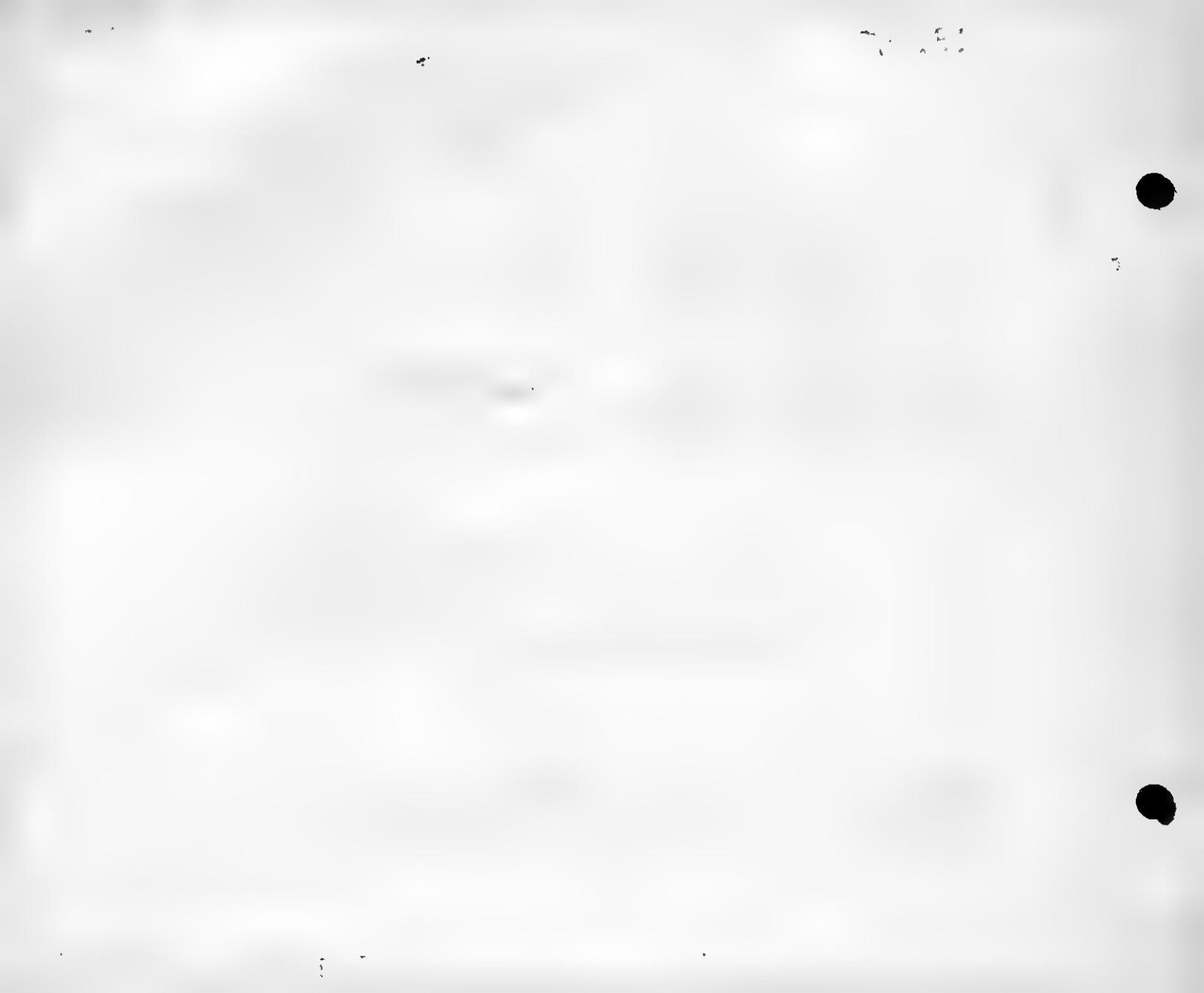


CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)	First <i>Robert</i>	Middle <i></i>	Last <i>Dosik</i>	2a DATE OF DEATH Month <i>Sept.</i> Day <i>29</i> Year <i>68</i>	2b HOUR <i>8:50 AM</i>
3 SEX <i>Male</i>	4 RACE <i>white</i>	5. DATE OF BIRTH <i>8/25/12</i>		6. AGE (In years last birthday) <i>56</i> YRS	7. IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> M.M.
7a. BIRTHPLACE (State or foreign country) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Louis</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Entertainer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Entertainer</i>	
13a. U.S.G. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. MILE & CTY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>7500-GRANADA DR.</i>	
14. FATHER'S NAME First <i>Harry</i>	Middle <i></i>	Last <i>Dosik</i>	15. MOTHER'S MAIDEN NAME First <i>Esther</i>	Middle <i></i>	Last <i>Dosik</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>Yes, 1942-46 Army</i>	16b. SOCIAL SECURITY NO. <i></i>	17. INFORMANT WIFE <i>MRS. ETHEL DOSIK - 7500 GRANADA DR. BETH. MD.</i>	Address <i>5 days ago</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter any one cause per 1 or part (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypocardiac Defaction, acute</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) <i>this hospital</i> attended the deceased from <i>8-24</i> , 19 <i>68</i> , to <i>9-29</i> , 19 <i>68</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>8-24</i> , 19 <i>68</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> <i>(did)</i> (did not) view the body after death.					
22b. SIGNATURE <i>Devere Shuman</i>	DEGREE <i></i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9-29-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Devere Shuman</i>	22e. ADDRESS <i>915-19th ST. N.W.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>10-1-68</i>	23c. NAME OF CEMETERY OR CEMATORIAL <i>MT. LEBANON CEM.</i>	23d. LOCATION (City or Town) <i>HYATTSVILLE</i>	(County) <i></i>	(State) <i>MD.</i>
24. FUNERAL DIRECTOR <i>BERNARD DANZANSKY & SONS - WASH. D.C.</i>	ADDRESS <i></i>	25a. RECD BY REGISTRAR DATE <i>OCT. 1 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (if filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death).



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13117

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13129

1 DECEASED NAME (Type or Print)	First <i>Tda</i>	Middle <i>Elizabeth</i>	Last <i>Dove</i>	2a DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/>	Month <i>Sept</i>	Day <i>26</i>	Year <i>1968</i>	2b HOUR <i>3:30 A.M.</i>					
3 SEX <i>F</i>	4 RACE <i>Negro</i>	S. DATE OF BIRTH <i>9/26/02</i>	6 AGE (in years last birthday) <i>66</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	HOURS <i>0</i>	MIN. <i>0</i>	2c DATE PRONOUNCED DEAD Month <i>Sept</i>	Day <i>26</i>	Year <i>1968</i>	2d HOUR <i>4:45 P.M.</i>		
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>									
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Rockville</i>	13d INSIDE CITY LIMITS <input type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>110 Frederick Ave.</i>									
14 FATHER'S NAME <i>Lewis</i>	First <i>Lewis</i>	Middle <i>Vinson</i>	Last <i>None</i>	15 MOTHER'S MAIDEN NAME <i>Louise</i>	First <i>Louise</i>	Middle <i>Martin</i>	Last <i>None</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b SOCIAL SECURITY NO. (If yes give war or dates of service)	17 INFORMANT <i>Rosie Carter - daughter.</i>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Fatty Metamorphosis of Liver-Acute-Sudden.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Chronic Alcoholism.</i> (b) <i>Chronic Alcoholism.</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>5/11/01</i>													
19a DATE OF OPERATION <i>5/11/01</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>While at work</i>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Autopsy</i>										
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John S. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								22b DATE SIGNED <i>Sept 26, 1968.</i>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)									
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE <i>9-29-1968</i>	23c NAME OF CEMETERY OR CREMATORIUM <i>Lincoln Park Cem.</i>		23d LOCATION (City or Town) <i>Rockville Montg. Md.</i>		(County) <i>Montgomery Co.</i>		(State) <i>Md.</i>					
24 FUNERAL DIRECTOR <i>Robert L Snowden Rockville Md.</i>	ADDRESS	25a REC'D BY REG STRR <i>OCT 1 1968</i>		25b REGISTRAR'S SIGNATURE <i>James George</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

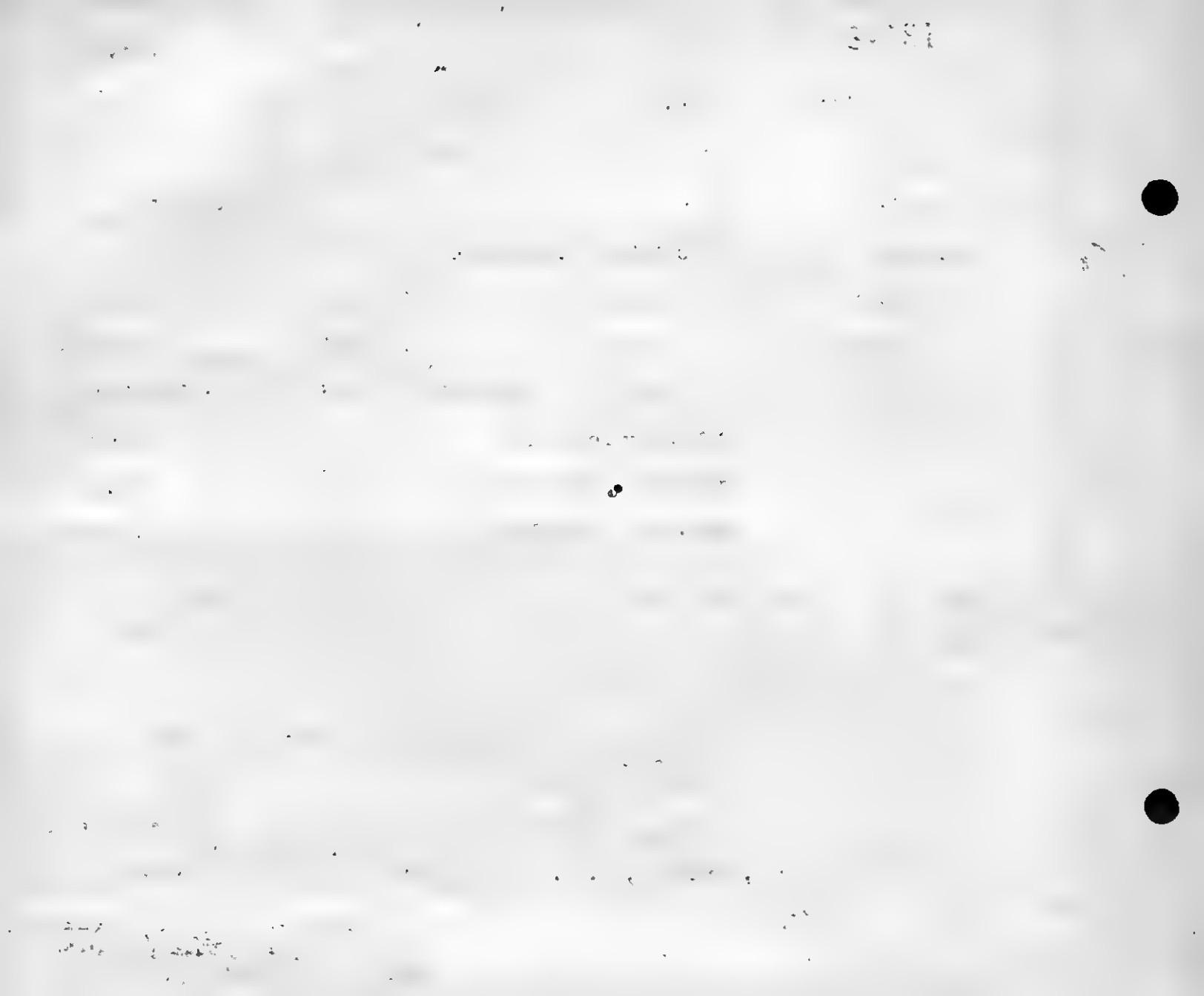
13118

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13130

1. DECEASED NAME (Type or print)	First Nikol	Middle (NMN) Drisos	Last Drisos	2a. DATE OF DEATH Month September Day 19 Year 1968	2b. HOUR AM 1:50 M
3. SEX Male	4. RACE White	S. DATE OF BIRTH 31 August 1959	6. AGE (In years last birthday) 9 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0
7a. BIRTHPLACE (State or foreign country) Greece	7b. CITIZEN OF WHAT COUNTRY? Greece	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student	12b. KIND OF BUSINESS OR INDUSTRY --		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Greece	13c. CITY OR TOWN Kargies, Hios	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER No Street Address		
14. FATHER'S NAME First Emanoel	Middle Drisos	15. MOTHER'S MAIDEN NAME First Kalliopis	Middle Dimandidou		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None	17. INFORMANT Bethesda, Maryland 20014	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage <i>156.2</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Tetralogy of Fallot			2 Days		
DUE TO, OR AS A CONSEQUENCE OF Congestive Heart Failure			2 Days		
DUE TO, OR AS A CONSEQUENCE OF Tetralogy of Fallot			9 Years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 16 August 1968 , to 15 Sept. 1968 , that <input type="checkbox"/> (we) last saw the deceased alive on 15 September 1968 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <i>Charles L. McIntosh, M.D.</i>		22c. DATE SIGNED 15 September 1968			
22d. PHYSICIAN'S NAME (Type) Charles L. McIntosh, M. D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 8-18-68	23c. NAME OF CEMETERY OR CREMATORIAL —	23d. LOCATION (City or Town) KARGIES HIOS, GREECE	(County) (State)
24. FUNERAL DIRECTOR W.W. Chambers Co.		ADDRESS 1450 Chapin St. N.W.	25a. RECD BY REGISTRAR Wade D.C.	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE SEP 16 1968



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

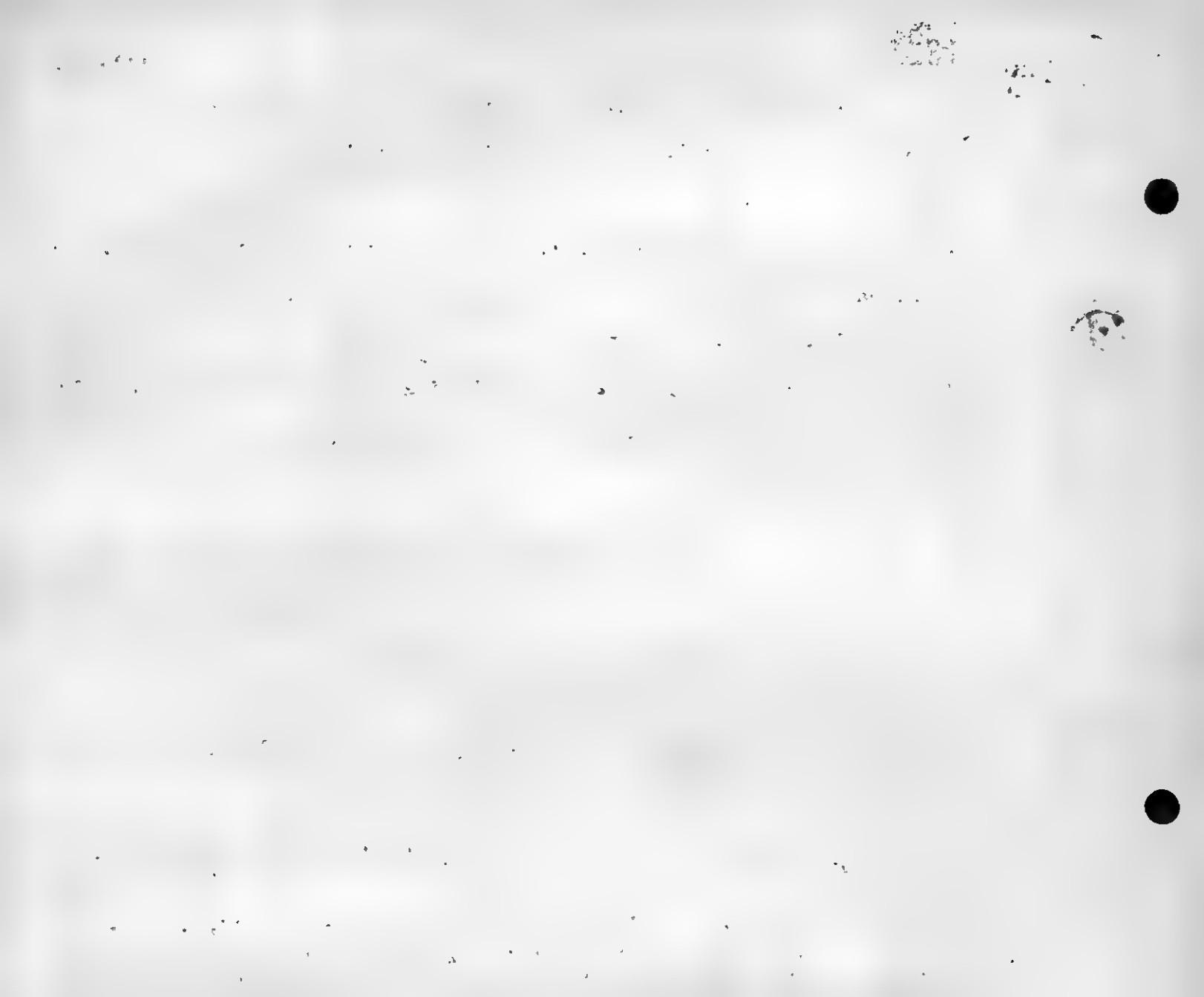
CERTIFICATE OF DEATH

13131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR A 3:20 M
Theodore				(NMN)		Dunn	September 20, 1968	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 29 September 1906		6. AGE (In years last birthday) 61		F YOUNG 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md.
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Usual: Harvester		12b. KIND OF BUSINESS OR INDUSTRY Agriculture		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Florida		13b. COUNTY --		13c. CITY OR TOWN Groveland		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER P. O. Box 53	
14. FATHER'S NAME William		First V.	Middle Dunn	15. MOTHER'S MAIDEN NAME Mariam		Middle Melvin	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 265-07-5205		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY.</p> <p>IMMEDIATE CAUSE (o) General mycosis fungoides with cachexia</p> <p><i>2021</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b)</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>								
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)</p> <p><i>2021</i></p>								
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State 20
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 20, 1968 , to September 19, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 20, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.								
22b. SIGNATURE <i>Ervin Epstein, M.D.</i>		22c. DATE SIGNED 21 September 1968						
22d. PHYSICIAN'S NAME (Type) Ervin Epstein, M. D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9/22/68		23c. NAME OF CEMETERY OR CREMATORIUM Lake Mary Cemetery.		23d. LOCATION (City or Town) Lake Mary, Semin, Florida		(County) (State)
24. FUNERAL DIRECTOR <i>Robert A. Humphrey</i>		ADDRESS <i>McGraw Building Bethesda, Md.</i>		25a. REC'D BY REGISTRAR SEP 27 1968		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>		



13120

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

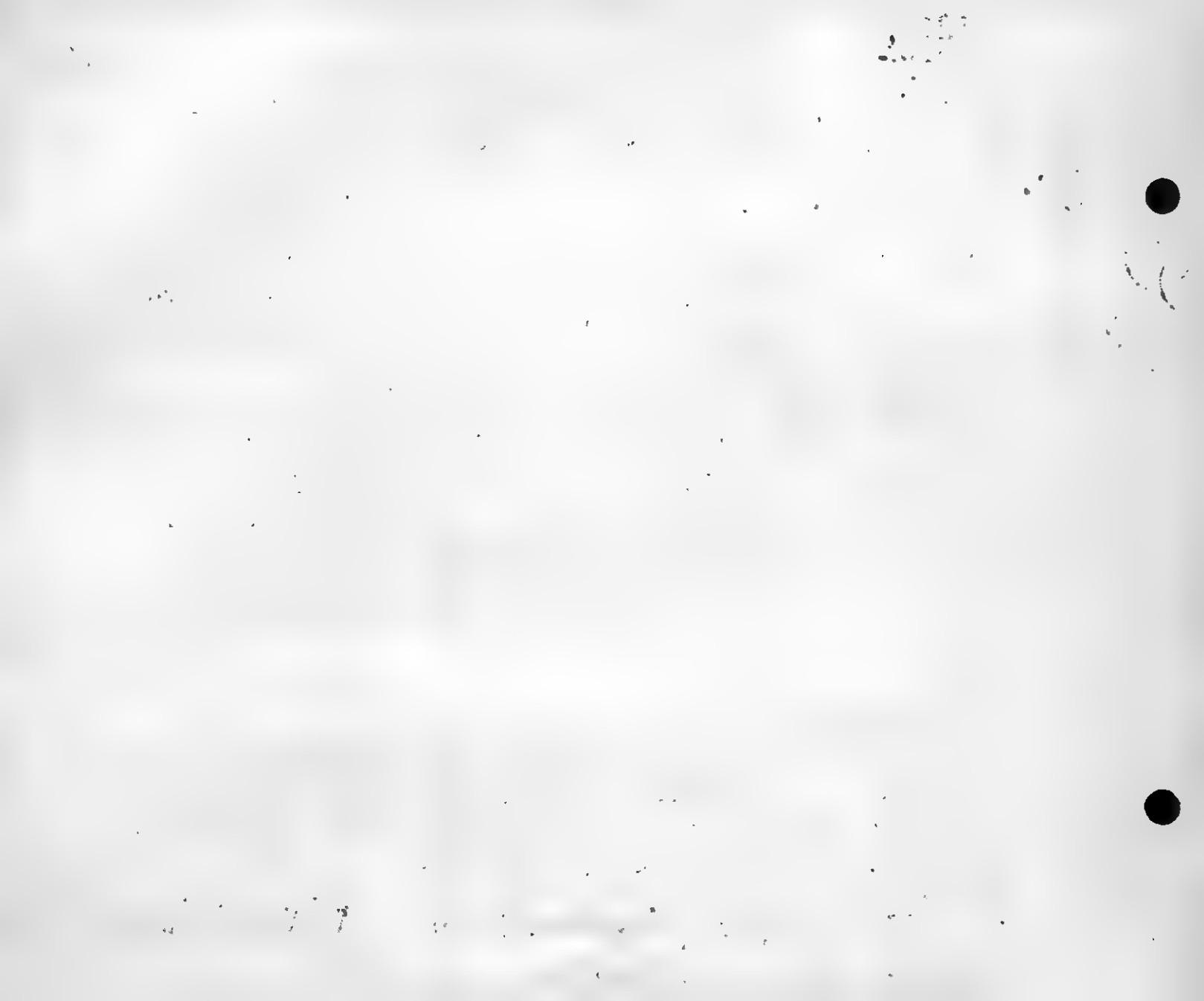
13132

1. DECEASED NAME (Type or print)	First BABY BOY	Middle EADER	Last EADER	2a. DATE OF DEATH Month 9 - 15	Day 15	Year 68	2b. HOUR 04 P.M.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 9-15-68		6. AGE (In years last birthday) YRS. 12		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium and Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Infant		12b. KIND OF BUSINESS OR INDUSTRY SANTINI ROAD			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md	13b. COUNTY MONTGOMERY BURTONSVILLE	13c. CITY OR TOWN MONTGOMERY BURTONSVILLE	13d. INSIDE CITY LIMITS? YES	NO	13e. STREET AND NUMBER 155515	13f. ADDRESS SANTINI ROAD		
14. FATHER'S NAME First Gary	Middle Roy	Last Eader	15. MOTHER'S MAIDEN NAME First Marceia	Middle Elizabeth	Last Conger	Address Hosp. Record.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. _____	17. INFORMANT Respiratory Distress Syndrome	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF Prematurity Birth (28-30 weeks DUE TO, OR AS A CONSEQUENCE OF (c) gestation)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 1735								
19a. MEDICAL CERTIFICATION DATE OF OPERATION 1735	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. _____	City or Town _____	County _____	State _____			
22a. I certify that (I) (this hospital) attended the deceased from 9-15-68 , to 9-15-68 , that (I) (we) last saw the deceased alive on 9-15-68 and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE ALLAN B. COLEMAN	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-15-68			
22d. PHYSICIAN'S NAME (Type) ALLAN B. COLEMAN	22e. ADDRESS 1655 N. PORTAL DR. NEW WASH 20012							
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE 9/19/68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Burtonsville, Md.	23d. LOCATION (City or town) Burtonsville	(County) Md.	(State) Md.			
24. FUNERAL DIRECTOR Donaldson S. H.	ADDRESS Laurel Md.	25a. REC'D BY REGISTRAR DATE SEP 19 1968	25b. REGISTRAR'S SIGNATURE J. Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.> VR A13
30M REV. 6/68

51-24



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

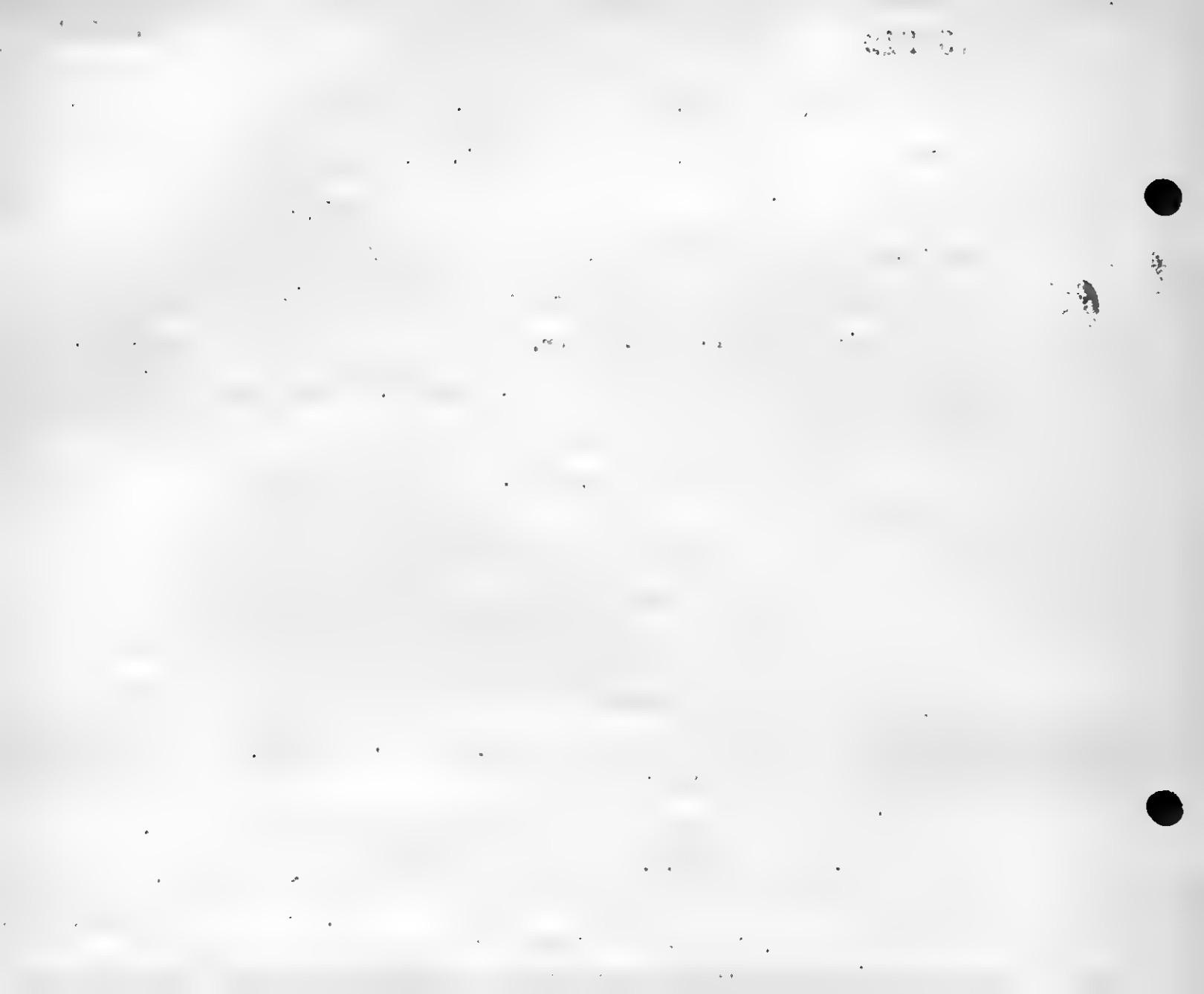
13133

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in ~~by~~ Funeral Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type at print) First Baby			Middle Girl	Last EDWARDS	2a DATE OF DEATH Month Sept Day 11 Year 68	2b. HOUR P 1055 M	
3 SEX Female		4. RACE Caucasian		S. DATE OF BIRTH Sept. 10, 1968	6. AGE (in years last birthday) YRS 1	IF UNDER 1 YEAR MONTHS 1	IF UNDER 24 HRS HOURS 1
7a. BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A		12b KIND OF BUSINESS OR INDUSTRY N/A
13a. US/JAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 5622 Oak Place	
14. FATHER'S NAME First Walter		Middle Garland	Last EDWARDS Jr.	15. MOTHER'S MAIDEN NAME First Mary	Middle Jane	Last DICKERSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, N/A (If yes, give war or dates of service)		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Bethesda, Lt. Walter G. Edwards, USN 5622 Oak Place	Address Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary hypoplasia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7544							
DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) Multiple congenital anomalies							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7545							
19a. DATE OF OPERATION 7545	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22o. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1968 , to Sept. 11, 1968 , that (I) (we) lost saw the deceased alive on Sept. 11, 1968 , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.							
22b. SIGNATURE B. Jay Bortz, M.D.		DEGREE ATTENDING PHYS	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/> 22c. DATE SIGNED Sept. 12, 1968
22d. PHYSICIAN'S NAME (Type) B. Jay BORTZ, M.D.		22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) 9/13/68		23b. DATE 9/13/68	23c. NAME OF CEMETERY OR CREMATORIAL Elmwood Cemetery		23d. LOCATION (City or Town) Columbia, Richland, S.C. (County) (State)		
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Funeral Home 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR Charles J. George		25b. REGISTRAR'S SIGNATURE SEP 18 1968	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13122

13134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First <i>Martin</i>	Middle <i>D.</i>	Last <i>Eisen</i>	2a. DATE OF DEATH 9 Month 9 Day Year 68	2b. HOUR 3:48 P.M.	
3. SEX MALE		4. RACE WHITE		S. DATE OF BIRTH <i>6-3-11</i>	6. AGE (In years last birthday) <i>58 yrs</i>		
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Pharmacist		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. CITY OR TOWN <i>MONT.</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>1109 Loxford Terr.</i>		
14. FATHER'S NAME First SAMUEL		Middle <i>EISEN</i>	Last <i>TOSY</i>	15. MOTHER'S MAIDEN NAME First <i>KLEIN</i>	Middle <i></i>	Last <i></i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-01-8484</i>		17. INFORMANT <i>Florence Eisen</i>	Address <i>(Same as 13 above)</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>							
41 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Coronary Thrombosis</i> 3 days							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arterio-arteric Cardio Vasculitis</i> 9 month							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>19</i> Day <i>19</i> Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>
22a. I certify that (I) (this hospital) attended the deceased from <i>9/4/68</i> , 19, to <i>9/7/68</i> , 19, that (I) (we) last saw the deceased alive on <i>9/7/68</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Samuel Eisen, MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>9/7/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Samuel Eisen, MD</i>		22e. ADDRESS <i>4201 Mass Ave N.E.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-9-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Georgetown Cem.</i>		23d. LOCATION (City or Town) <i>Hyattsville</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
24. GENERAL DIRECTOR <i>Goodale Jewelers</i>		ADDRESS <i>4217 9th St. NW</i>	25a. REC'D BY REGISTRAR <i>Charles J. Deen</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Deen</i>		
		DATE <i>SEP 10 1968</i>					



CERTIFICATE OF DEATH

13135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 2 and 2½ hours after death. This certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>SUSAN McCort</i>	Middle <i>Emery</i>	Last <i></i>	2a DATE OF DEATH Month 9 Day 24 Year 68 10 51	2b HOUR
3 SEX <i>FEMALE</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>Sept 18, 1890</i>		6. AGE (In years last birthday) 78 yrs.	F YOUNG 1 YEAR MONTHS GAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) <i>Michigan</i>	7b. CITIZEN OF WHAT COUNTRY? <i>US</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Rockville, md</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Potomac Valley Nursing Home</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i></i>	12b KIND OF BUSINESS OR INDUSTRY <i></i>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Res. before admission) <i>D.C.</i>	13b CITY OR TOWN <i>D.C.</i>	13c CITY OR TOWN <i>Washington</i>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>3636 16th St. Wash. DC</i>	
14 FATHER'S NAME First <i>Andrew</i>	Middle <i>McCort</i>	Last <i></i>	15 MOTHER'S MAIDEN NAME First <i>Noira</i>	Middle <i></i>	Last <i>Goodspeed</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>	16b. SOCIAL SECUR. NO. <i>361-01-6391</i>	17 INFORMANT <i>SUSAN M Ellis Rt # 232 C Boyds Md</i>	Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute & Chronic Congestive</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) <i>Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF, (c) <i>Arteriosclerosis</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 months</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED at home <input type="checkbox"/> Not while at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 10, 1968</i> , to <i>Sept. 28 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept. 20 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Jack Schumacher</i>	DEGREE <i></i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>Sept. 25, 1968</i>		
22d. PHYSICIAN'S NAME (Type) <i>Dr. J. Schumacher</i>	22e. ADDRESS <i>105 Russell Ave, Gaithersburg</i>				
23a. BURIAL, CREMATION, CREMATORIUM <i>Cremation</i>	23b. DATE <i>9-25-68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Crematory</i>	23d. LOCATION (City or Town) <i>Suitland</i>	(County) <i>Pr. Geo</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>	25a. ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>	25b. REC'D BY REGISTRAR DATE <i>SEP 27 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

100

100

100

13124

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 13 Film G-1000

13136

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain, and in any event, within 72 hours, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours.

1 DECEASED NAME (Type or print)	First	Middle	Lost	2a DATE OF DEATH Month	2b HOUR Year	
<i>MARK Christopher EVANS</i>				9	5-20 88	
3 SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.
<i>MALE</i>	<i>White</i>	<i>9-21-68</i>	<i>—</i>	3	45	
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH	Md		
<i>Md.</i>	<i>U.S.</i>		<i>MONTGOMERY</i>			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
<i>Bethesda</i>	<i>Silverbrook</i>					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
<i>Maryland</i>	<i>Montgomery</i>	<i>Gaithersburg</i>	<i>—</i>	<i>213 Oakton Rd.</i>		
14 FATHER'S NAME	First	Middle	Lost	15 MOTHER'S MAIDEN NAME	First	Middle
<i>C. Barry</i>				<i>Patricia Ann</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17 INFORMANT	Address			
		<i>C. Barry Evans</i>	<i>213 Oakton Rd. Gaithersburg, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxia</i>						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
7762 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>7762</i>						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>RESPIRATORY DISTRESS SYNDROME</i>						
DUE TO, OR AS A CONSEQUENCE OF (c) <i>IMMATURE</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Michael Buckley</i>	DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9-22-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>MICHAEL BUCKLEY</i>	22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9-25-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate Of Heaven</i>	23d. LOCATION (City or Town) (County) <i>SilverSpring, Montg., Md.</i>	(State)		
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>	ADDRESS <i>GAITHERSBURG, MD.</i>	25a. REC'D BY REGISTRAR DATE <i>SEP 24 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>			

left in

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office alone with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												MEDICAL EXAMINER'S CERTIFICATE OF DEATH			13137												
2/21/69 kk												2d. HOUR															
1. DECEASED NAME (Type or Print)				Middle				Lost				2a. DATE KNOWN OF ESTI- MATED			Month	Day	Year	2b. HOUR									
<i>Augusta</i>								<i>Ey</i>				<input checked="" type="checkbox"/>			<i>9-5-</i>	<i>18</i>	<i>6A.M.</i>	<i>35</i>									
3. SEX		4. RA		5. DATE OF BIRTH		1887		6. AGE (In years last birthday)		IF UNDER 1 YEAR		7. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD													
<i>F</i>		<i>W</i>		<i>4/30/1917</i>		<i>77 yrs</i>		<i>1/2</i>		MONTHS		DAYS		HOURS		MIN		Month			Day		Year		2d. HOUR		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8.		CITIZEN OF WHAT COUNTRY?		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. COUNTY OF DEATH											
<i>New York</i>		<i>USA</i>						<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<i>Montgomery</i>											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY															
<i>Bethesda</i>				<i>Suburban</i>																							
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER															
<i>Md.</i>				<i>Montgomery</i>				<i>Bethesda</i>				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				<i>4305 Kettbury Drive</i>											
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MARRIED NAME		First		Middle		Last											
<i>Unknown</i>										<i>Unknown</i>																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS															
<i>—</i>				<i>579-32-4162</i>				<i>Ey</i>				<i>4305 Kettbury Drive</i>															
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				19. OTHER CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
<i>41</i>				<i>Acute Coronary Insufficiency</i>																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.				<i>Arteriosclerotic Heart Disease</i>																							
(b)																											
(c)																											
21a. DATE OF OPERATION				21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				20. AUTOPSY?															
<i>4/20/1</i>												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
21d. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21e. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21f. LOCATION Street or R.F.D. No.				City or Town		County		State											
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21h. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)																							
22a. I certify that I took charge of the remains described above, held on				Autopsy <input type="checkbox"/>				Inspection <input checked="" type="checkbox"/>				Inquiry <input checked="" type="checkbox"/>				and in my opinion											
death resulted from:				Natural causes <input checked="" type="checkbox"/>				Accident <input type="checkbox"/>				Suicide <input type="checkbox"/>				Homicide <input type="checkbox"/>				Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		<i>Belden R. Peeples</i>												CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED									
EXAMINER'S NAME (Type)		<i>BELDEN R. PEEPLES, M.D., Pathologist</i>												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS <i>4305 Kettbury Drive, Bethesda, MD</i>		<i>SEPT. 5, 1968</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION (City or Town)				(County)		(State)													
<i>Burial</i>		<i>9-9-68</i>		<i>Arlington National</i>				<i>Arlington</i>				<i>Virginia</i>															
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE																	
<i>Robert A. Pumphrey</i>		<i>7557 Wisconsin Ave Bethesda, MD</i>				<i>SEP 10 1968</i>				<i>Charles Judge</i>																	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13126

CERTIFICATE OF DEATH

13138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. DECEASED-NAME (Type or print)	First <u>LUTA</u>	Middle <u>S.</u>	Last <u>FERRELL</u>	2a. DATE OF DEATH Month <u>Sept</u>	Day <u>29</u>	Year <u>1968</u>	2b. HOUR <u>11:30 A.M.</u>
3. SEX <u>FEMALE</u>	4 RACE <u>WHITE</u>	5. DATE OF BIRTH <u>8/10/1885</u>		6. AGE (In years last birthday) <u>83 yrs.</u>	IF UNDER 1 YEAR MONTHS <u>0</u>		IF UNDER 24 HRS. HOURS <u>0</u>
7a. BIRTHPLACE (State or foreign country) <u>Virginia</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>MONTgomery</u>				
10. CITY OR TOWN OF DEATH <u>BETHESDA</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>SUBURBAN</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Pumpkin</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE <u>WASHINGTON</u>	13c. CITY OR TOWN <u>D.C.</u>	13d. INSIDE CITY LIMITS? <u>YES</u>	13e. STREET AND NUMBER <u>1616 OTIS ST. N.W.</u>				
14. FATHER'S NAME <u>Polk</u>	Middle <u>WARNER</u>	Last <u>MARY LAVINIA</u>	15. MOTHER'S MAIDEN NAME First <u>ELIZABETH D WHITTLESEY</u>	Middle <u>Pumpkin</u>	Last <u>Address 3340 Glenridge Drive S.S. 20854</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u>	16b. SOCIAL SECURITY NO. <u>*****</u>	17. INFORMANT <u>None</u>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Probable Ruptured Colon Diverticulitis</u>							
(b) <u>Diverticulitis</u>							
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Vesico Vaginal Fistula & Hemorrhage</u>							
19a. MEDICAL CERTIFICATION	19c. DATE OF OPERATION	19d. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at play <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/27/68</u> to <u>9/29/68</u> , that (I) (we) last saw the deceased alive on <u>9/28/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James W. Egan</u>	DEGREE <u>MD</u>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>9/29/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>JAMES W. EGAN</u>	22e. ADDRESS <u>5412 Cedar Lane, Bethesda, Maryland</u>						
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/2/68</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Glenwood Cemetery</u>	23d. LOCATION (City or Town) <u>Washington</u>	(County) <u>D.C.</u>	(State)		
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>	25a. ADDRESS <u>7557 Wisconsin Ave.</u>	25b. REC'D BY REGISTRAR <u>DATE OCT 2 1968</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2d. DATE OF DEATH Month Day Year		2b. HOUR Hour Min
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		Address
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		5 days	
431.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Thrombosis of posterior artery				68 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town	
22a. I certify that (I) (this hospital) attended the deceased from 8 July, 1968, to 11 Sept, 1968, that (I) (we) last saw the deceased alive on 14 Sept, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						County State	
22b. SIGNATURE		MD		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 14 Sept 68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS			
23a. BURIAL, CREMATION, CREMATORIAL SERVICE		23b. DATE 9-18-1968		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION (City or Town) Suitland, P.C.O., Maryland	
24. FUNERAL DIRECTOR Joseph Cawler's Sons, Inc., 3130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 18 1988		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13128

CERTIFICATE OF DEATH

13140

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Ralph</i>	Middle <i>LYMAN</i>	Last <i>Flynn</i>	2a. DATE OF DEATH Month <i>9 - 11 - 68</i>	Day <i>Year</i>	2b. HOUR <i>3:15 P.M.</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>5-19-05</i>		6. AGE (In years last birthday) <i>65</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Ind.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery County, Md.</i>	10. CITY OR TOWN OF DEATH <i>Silver Spring, Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Montgomery</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>Box 77 Mayo</i>			
14. FATHER'S NAME First <i>Thomas</i>	Middle <i>T.</i>	Last <i>Flynn Jr.</i>	15. MOTHER'S MAIDEN NAME First <i>Adelaide Estelle Jones</i>	Middle <i>Estelle</i>	Last <i>Jones</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown <input type="checkbox"/>	16b. SOCIAL SECURITY NO <i>115-14-7252</i>	17. INFORMANT <i>Louis Freed</i>	Address <i>Mayo, Md</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1707</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>metastatic nodules in both lungs.</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(b) DUE TO, OR AS A CONSEQUENCE OF <i>metastatic nodules in both lungs.</i>							
(c) DUE TO, OR AS A CONSEQUENCE OF <i>None</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>							
19a. DATE OF OPERATION <i>1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING □ CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While □ Not while at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC) <i>None</i>	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>1968</i> , to <i>1968</i> , that (I) (we) last saw the deceased alive on <i>9/11/68</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Hugh Irey</i>		M.D. DEGREE <input checked="" type="checkbox"/>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9/11/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Hugh Irey, M.D.</i>		22e. ADDRESS <i>11161 New Hamp.Ave., S.S., Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Sept 14, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Our Lady of Sorrows</i>	23d. LOCATION (City or Town) (County) <i>Owensville, PA</i>	(State) <i>Md</i>		
24. FUNERAL DIRECTOR <i>Hordestey Funeral Home, Annapolis, Md.</i>		ADDRESS <i>Annapolis, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>SEP 18 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13141

1 DECEASED NAME (Type or print)	First CORNELIA	Middle WILLIAMS	Last FOWLER	2a DATE OF DEATH SEPT. Month 12 Day 1968 Year 1968	2b HOUR 5:45 P.M.
3 SEX FEMALE	4. RACE WHITE	S DATE OF BIRTH 8-26-1885	6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) MASS.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY COUNTY	10c. TOWN OF DEATH CHEVY CHASE SPRING NURSING HOME	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BETHESDA-SILVER SPRING NURSING HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) WASHINGTON D.C.	13b. COUNTY	13c. CITY OR TOWN WOODLEY PARK, D.C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2800 WOODLEY RD. N.W.	
14. FATHER'S NAME First EDWARD H. WILLIAMS JR.	Middle	Last	15. MOTHER'S MAIDEN NAME First JENNIE	Middle	Last BEMIS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown WW I	16b. SOCIAL SECURITY NO. 130-07-8955	17. INFORMANT DR. WENTWORTH WILLIAMS, BROTHER	Address GROTON, CONN.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Brachopneumonia APPROXIMATE INTERVAL BETWEEN DISEASE AND DEATH 40 days Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost Ortodox Salviatic Heart Disease 4 years (b) Generalized Artherosclerosis (c) Generalized Artherosclerosis					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200					
19a. DATE OF OPERATION 4/20/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Sept 12, 1968 to Sept 12, 1968 , that (I) (we) last saw the deceased alive on Sept 12, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Herbert Blauersfeld M.D.	Degree M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9/12/68
22d. PHYSICIAN'S NAME (Type) Herbert Blauersfeld M.D.	22e. ADDRESS 2401 Calvert St. N.W.				
23a. BURIAL CREMATION, CREMATORIUM (Specify)	23b. DATE 9-13-1968	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematory	23d. LOCATION (City or Town) Suitland, Prince Georges Co.	(County)	(State) Md.
24. FUNERAL DIRECTOR Joseph Fowler's Sons, Inc.,	ADDRESS 5130 Wisc. Ave. N.W., Wash., D.C., 20016	25a. REC'D BY REGISTRAR DATE SEP 18 1988	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13130

13142

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 2, hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR P.M.			
Lillie (Lily) IRENE FOX						Sept. 27, 1968					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Nov. 12, 1882</i>		6. AGE (in years last birthday) <i>85</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. lot) <i>Suburban Hospital</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Montgomery Rockville</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Transit load</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission). STATE <i>MARYLAND</i>		13c. CITY OR TOWN <i>Montgomery</i>		13d. INSIDE CITY LIMITS? <i>YES <input type="checkbox"/> NO <input type="checkbox"/></i>		13e. STREET AND NUMBER <i>13831 Transith Load</i>					
14. FATHER'S NAME First <i>Jacob</i>		Middle <i>Cronn</i>	Last <i>Nancy</i>	15. MOTHER'S MAIDEN NAME First <i>Mildred Poole - daughter</i>		Middle <i>Drenenberry</i>	Last <i>25504 Woodfield - Damascus, Md.</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>4110</i>		17. INFORMANT <i>Mildred Poole - daughter</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 minutes</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>(b)</i> DUE TO, OR AS A CONSEQUENCE OF <i>(c)</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>14</i>											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>fall</i>						
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>E. L. Molesworth, Jr., M.D.</i>										22c. DATE SIGNED <i>Oct. 1, 1968</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>2707 Church Street, Baltimore, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct. 1, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Zion Meth.</i>			23d. LOCATION (City or Town) <i>McKrig, Md.</i>		(County)	(State)	
24. FUNERAL DIRECTOR <i>Olin L. Molesworth, Damascus, Md.</i>		ADDRESS			25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE				



FOR STATE
HEALTH DEPT.



TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form M-2, Bone 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1313

13143

1 DECEASED NAME (Type or Print)	First HORTENSE	Middle NMN	Last FREEMAN	2a DATE KNOWN OF EST DEATH MATED <input type="checkbox"/>	Month 9	Day 28	Year 68	2b H.O.R. 10:50A	
3 SEX FEMALE	4. RACE WHITE	5 DATE OF BIRTH 12-20-83	6 AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> M.N. <input type="checkbox"/>	7c. DATE PRONOUNCED DEAD Month 9	Day 28	Year 1968	2d HOUR 10:50A	
7a BIRTHPLACE (State or foreign country) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery						
10 CITY OR TOWN OF DEATH Olney, Maryland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk	12b KIND OF BUSINESS OR INDUSTRY U.S. Government				
13a US-JAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c CITY OR TOWN Spencerville	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 16004 Batson Road					
14. FATHER'S NAME <i>Unknown Arnold A. Freeman</i>	First <i>Arnold</i>	Middle <i>A. Freeman</i>	Last <i></i>	15 MOTHER'S MAIDEN NAME <i>Unknown Josephine L. Price</i>	First <i>Josephine</i>	Middle <i>L. Price</i>	Last <i></i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No	16b SOCIAL SECURITY NO (If yes give war or dates of service)	17 INFORMANT Medical Records, Mont. Gen. Hosp., Olney, Md	ADDRESS						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchial Pneumonia - DUE TO, OR AS A CONSEQUENCE OF (b) Toxemia of Sepsis. of Fractured Hts. DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis -					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days?				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Fracture of R. hip									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 704.0									
19a. DATE OF OPERATION 29 July 68		19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Repair of fracture R. hip Prosthetic joint			20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR <input type="checkbox"/> P.M. July 27 1968	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fell at home causing fracture of R. hip							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home	21f LOCATION Street or R.F.D. No 16004 Batson Rd.	City or Town Spencerville	County Mont.	State Md.				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John S. Bell</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.								
EXAMINER'S NAME (Type) <i>John S. Bell</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Montgomery, MD</i>								
23a BURIAL, CREMATON, REMOVAL (Specify) Burial	23b DATE Oct 2nd 68	23c NAME OF CEMETERY OR CREMATORIUM St Marks	23d LOCATION (City or Town) Honey Brook (Eustis) Md.	(County) (Eustis)	(State) (Md.)				
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>	ADDRESS <i>Gaithersburg, Md.</i>	25a REC'D BY REGISTRAR DATE SEP 30 1968	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



²⁰13144

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First <i>George</i>	Middle <i>Ferr</i>	Lost	20. DATE OF DEATH 9 Month 18 Day 68 Year	26. HOUR 24. M
3. SEX <i>Female</i>	4. RACE <i>Caucas.</i>	5. DATE OF BIRTH <i>8-15-1882</i>		6. AGE (in years lost birthday) <i>86</i> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. B. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery County</i>	
10. CITY OR TOWN OF DEATH <i>Wheaton, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>901 Rockville Rd., Wheaton, Maryland</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Businessman</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>Wash. D.C.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>1003 Quebec Place N.W. 20510</i>	
14. FATHER'S NAME First <i>Unknown</i>		Middle <i>Unknown</i>	Last <i>Unknown</i>	15. MOTHER'S MAIDEN NAME First <i>Unknown</i>		Middle <i>Unknown</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>(If yes give war or dates of service)</i>		17. INFORMANT <i>Alonzo Chichester</i> Address <i>1003 Quebec Place, N.W.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>lymphocytic leukemia</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>2047</i>		(b) _____ DUE TO, OR AS A CONSEQUENCE OF				
		(c) _____ DUE TO, OR AS A CONSEQUENCE OF				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						
21a. MEDICAL CERTIFICATION		21b. DATE OF OPERATION		21c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>8 Jan 1968</i> to <i>18 Sept 1968</i> , that (I) (we) lost saw the deceased alive on <i>17 Sept 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Walter E. Goode MD</i>		DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>20 Sep 1968</i>
22d. PHYSICIAN'S NAME (Type) <i>WALTER E. GOODE MD</i>		22e. ADDRESS <i>2309 Shorefield Rd Wheaton MD</i>				
23a. BURIAL, CREMATION, REMAINDERS <input checked="" type="checkbox"/>		23b. DATE <i>9/20/1968</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Lincoln</i>		23d. LOCATION (City or Town) <i>Suitland, Maryland</i>	(County) <i>(State)</i>
24. FUNERAL DIRECTOR <i>W. E. Jarvis Co.</i>		ADDRESS <i>1432 1/2 1st St. N.W.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the director, page 3 should be detached for use as the burial-transit slip. It should be filed with the State Dept. of Health prior to burial.

VR A15
30M REY



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13132

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13145

1 DECEASED NAME (Type or Print)	First MARION	Middle M.	Last GANTT	2a DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> 2-24-68 19	Month Month	Day Day	Year Year	2b HOUR 8 P.M.
3 SEX Male	4 RACE White	5. DATE OF BIRTH 12-2-25	6 AGE (in years last birthday) 42 yrs	F UNDER 1 YEAR MONTHS 9	DAYS 22	IF UNDER 24 HRS HOURS	MIN.	2c DATE PRONOUNCED DEAD Month Month Day 24 Year 1968 11:40
7a BIRTHPLACE (State or foreign country) South Carolina	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Takoma Park,	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Active Duty			12b KIND OF BUSINESS OR INDUSTRY Navy	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.	13b COUNTY P.G.	13c CITY OR TOWN Langley Pk.	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e STREET AND NUMBER 8402 14th Ave.				
14. FATHER'S NAME Pinkney	First A.	Middle Gantt	Last	15. MOTHER'S MAIDEN NAME Ollie Powers	First	Middle	Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes	16b SOCIAL SECURITY NO 245-22-9819	17. INFORMANT Geraldine M. Gantt--Rockville, Md.			ADDRESS 1303 Crawford Dr.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia bilatera. <i>481X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 490X Addison's Disease -								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town			County	State	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>	M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b DATE SIGNED Sept. 25, 1968		
EXAMINER'S NAME (Type) John G. Ball	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) 2936 Old Georgetown Rd., Bethesda, Md.				
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE 9/30/68	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National			23d. LOCATION (City or town) Arlington, Virginia	23e. (County) (State)		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home	ADDRESS 1331 Rock Pike Rockville, Maryland			25a. REC'D BY REGISTRAR DATE SEP 30 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



1
FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13134 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13146

1 DECEASED NAME (Type or Print)		First Rebecca	Middle Berkeley	Last Garnett	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	Month 9	Day 19	Year 1968	2b HOUR 682:10 a.m.
3 SEX Female	4 RACE Negro	5 DATE OF BIRTH 10-27-10	6 AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 9 Day 19 Year 1968			2d HOUR 2:30 p.m.
7a. BIRTHPLACE (State or foreign country) Virginia	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery			Md.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) En Route to Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		CITY OR TOWN Rockville	13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Muncaster Mill Rd.			
14. FATHER'S NAME William Byrd		15. MOTHER'S MAIDEN NAME Virginia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia -</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>cirrhosis of Liver -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic Alcoholism -</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						years			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 9-22-68		23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park Cem.		23d. LOCATION (City or Town) Rockville Montg. Md.			
24. FUNERAL DIRECTOR Robert Snowden Rockville Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page

3 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the funeral director.

NO FUNERAL DIRECTOR: Page 3 shows Health prior to burial, cremation

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13147

1 DECEASED-NAME (Type or Print)		First	Middle	Lost	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR or 5A M			
Grant	C			Harvey	<input checked="" type="checkbox"/>	Sept 29	1968					
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 COUNTY OF DEATH	10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a US-JAI OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY	
Male	white	Aug 13 1958	10 yrs				Montgomery	Bethesda	Suburban	Student	**	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8		9		10d				
Calif		USA										
10c USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13a CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		12c				
Md		Mont		Bethesda		YES <input type="checkbox"/> NO <input type="checkbox"/>		7216 Millwood Court				
14. FATHER'S NAME		First	Middle	Lost	15 MOTHER'S MAIDEN NAME	First	Middle	Lost	12d			
John		J	Harvey		Patricia				Walney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17 INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		None		Mother		Same as above		40 hr.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subdural Hematoma Acute.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Trauma from head injury -</u> DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1366												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?								
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR <input type="checkbox"/> 7:30 P.M. Sept 27 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Hit in left ear with head of pugnole								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No City or Town County State 7216 Millwood Court Bethesda Montgomery Md								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		JOHN G. BALL		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED Sept. 29, 1968.				
EXAMINER'S NAME (Type)		JOHN G. BALL, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9/29/68		23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cemetery		23d. LOCATION (City or Town) Colma, San Mateo Co. Cal		(County) (State)				
Removal												
24. FUNERAL DIRECTOR		ADDRESS 7557 Wisconsin Ave		25a. REC'D BY REGISTRAR OCT 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						
ROBERT A. PHIPREY, Bethesda, Maryland												



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13136

13148

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR 1.30 P.M.
2. SEX <i>Female</i>	4 RACE <i>Negro</i>	5. DATE OF BIRTH <i>1-7-1894</i>	6. AGE (In years lost birthday) <i>74 yrs.</i>	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <i>Maryland</i>	10. CITY OR TOWN OF DEATH <i>Whitman, Md.</i>	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>901 Locust Ave</i>		12a. USUAL OCCUPATION (Kind of work done most of working life, even if retired) <i>univ. Nursing Nursing</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE <i>Wash. D.C.</i>	13b. COUNTY <i>D.C.</i>	13c. CITY OR TOWN <i>Washington, D.C.</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>4519 Sargent Rd. N.E.</i>	
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17. INFORMANT	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7-19-68</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arteriosclerosis</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i>	Indeterminate		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i>			Indeterminate		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>332X Georgia C for</i>					
19a. DATE OF OPERATION <i>6/20/68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>7-20</i> , 19 <i>68</i> , to <i>9-29</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9-21</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Robert T. Gibb</i>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>9-29-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Robert T. Gibb</i>	22e. ADDRESS <i>3632 Georgia Ave N.W. Wash. D.C.</i>				
23a. BURIAL/CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10/4/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel Cemetery</i>	23d. LOCATION (City or Town) <i>Bethel Cemetery</i>	(County) <i>Baltimore, MD</i>	(State) <i>MD</i>
24. FUNERAL DIRECTOR <i>Frazier</i>	ADDRESS <i>711 38th & L St., N.W.</i>	25a. REC'D. BY REGISTRAR DATE <i>OCT 3 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

19
19

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13137

13149

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. If any part of page 3 is removed, it must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Nellie</i>	Middle <i>Louise</i>	Last <i>George</i>	2a. DATE OF DEATH Month <i>Sept</i>	Day of Year <i>27</i>	2b HOUR <i>9:30 A.M.</i>	
3. SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>Mar. 23 - 1879</i>			6. AGE (In years last birthday) <i>89</i>	IF UNDER 1 YEAR MONTHS <i>YRS.</i>	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH <i>Montgomery</i>			10b. IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
10 CITY OR TOWN OF DEATH <i>Oney</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rocke Grove Foundation</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Postal Clerk</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Virginia</i>	13c. C.TY OR TOWN <i>Albermarle</i>	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>724 Northwood Ave.</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Post Office</i>	
14 FATHER'S NAME <i>First Middle Last</i> <i>Silvers Lucken George</i>	15. MOTHER'S MAIDEN NAME First Middle Last <i>MARTHA Hodges</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>231-07-4588</i>	17. INFORMANT <i>Mr. Rossey J. Eastham-2122 More Ave-Whit. DC</i>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>4137</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				TERMINAL PULM. EDEMA DUE TO, OR AS A CONSEQUENCE OF <i>CEREBRAL HEMORRHAGE</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS.</i>
(b) DUE TO, OR AS A CONSEQUENCE OF <i>A.S.C.V.D.</i>							6 Mo
(c)							YEARS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>47 SENILITY - PROLONGED UNCONSCIOUS STATE 6 Mo+</i>							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) P.M.		21d. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. LOCATION Street or R.F.D. No.	21f. City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>March 1964</i> , to <i>27 Sept 1968</i> , that (I) (we) last saw the deceased alive on <i>26 Sept 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Donald R. Lewis M.D.</i>	22c. DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	DATE SIGNED <i>37 Sept 68</i>		
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <i>700 Cloverly St., Silver Spring, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9/29/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Riverview Cemetery</i>		23d. LOCATION (City or Town) <i>Charolettsville, Alb. Va.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>	ADDRESS <i>7557 Wisconsin Ave., Bethesda, Maryland</i>	25a. REC'D BY REGISTRAR <i>OCT 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE
HEALTH DEPT.

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13138 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13150

1. DECEASED NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	F. UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS HOURS	MMN.		
Male	white	10/27/27	40 yrs						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD	
		U.S.A.		<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		Montgomery		Month	Day
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross		Fireman		Fireman			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Prince George, Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3965 Green Castle Rd.			
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
Ophelia		H.	Gibson		Anne M. Gibson				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(If yes give war or dates of service)		228-26-7651		Mrs. ANN M. GIBSON		3965 GREEN CASTLE Rd., Laurel, Md.		13 hr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tracheitis & Pulmonary Edema Acute 13 hr. due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Inhalation of chemical smoke. 13 hr. due to, or as a consequence of (c) Explosion of Phosphorus Smoke Bomb. 13 hr.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 11:52 P.M. Sept 26 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Smoke Bomb exploded in Hand.					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Novelty and Game Lab		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John G. Bell		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22b. DATE SIGNED Sept. 27, 1968.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Sept 30-1968		23c. NAME OF CEMETERY OR CREMATORY Heo Tech Cemetery		23d. LOCATION (City or Town (County)) P.G. Co.			
24. FUNERAL DIRECTOR Arthur Walters		25. ADDRESS 257 Carroll St.		26. REC'D BY REGISTRAR OCT 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15ME (5) TOM REV. 1/68									

120
120
120

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or removal, within 72 hours after death.

1. DECEASED-NAME (Type or print) Judithanne			First	Middle NMN	Last Gilbert	2a. DATE OF DEATH Month September 18 Year 1968	2b. HOUR P 3:00 M
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5 July 1943		6. AGE (In years last birthday) 23 YRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired.) Secretary		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Florida		13b. COUNTY Daytona Beach		13c. CITY OR TOWN Daytona Beach		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Harry		Middle Camagna		15. MOTHER'S MAIDEN NAME First Alice		Middle	Last Knight
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 266-66-5665		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20011		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia Due to, or as a consequence of bronchopneumonia and necrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of renal papillae Due to, or as a consequence of (c) Radiation recurrent carcinoma of cervix 2 weeks 2 weeks 1 year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1/15</i>							
19a. DATE OF OPERATION <i>1/15</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING OR CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 5 July 1968 , to 18 Sep 1968 , that <input type="checkbox"/> (we) last saw the deceased alive on 18 September 1968 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE <i>William C. Wood</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS	DATE SIGNED 18 September 1968
22d. PHYSICIAN'S NAME (Type) William C. Wood, MD		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20011					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9-19-68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) Port Orange (County) Fla (State)	
24. FUNERAL DIRECTOR Joseph Grawlers Sons		ADDRESS 5130 Wisconsin Ave., N.W., Wash., D.C.		25a. REC'D BY REGISTRAR DATE SEP 23 1968		25b. REG STAR'S SIGNATURE <i>Charles J. George</i>	



CERTIFICATE OF DEATH

13140

13152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First <i>Mabel</i>	Middle <i>P.</i>	Last <i>Gibbert</i>	2a. DATE OF DEATH Month Day Year <i>9 18 1968</i>	2b. HOUR <i>4:30pm</i>
3. SEX <i>Female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>March 7 1883</i>		6. AGE (in years last birthday) <i>85 yrs.</i>	<input type="checkbox"/> IF UNDER 1 YEAR <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.
7a. BIRTHPLACE (State or foreign country) <i>Frederick, Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Retired-Government Employee</i>	
10. CITY OR TOWN OF DEATH <i>Wheaton</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Randolph Hills Nursing Home 4011 Randolph</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret'd.) <i>Retired</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Employee</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Virginia</i>	13b. COUNTY <i>Arlington</i>	13c. CITY OR TOWN <i>Arlington</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>North Glebe Road</i>	
14. FATHER'S NAME First <i>George Andrew</i>	Middle <i>Gibbert</i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Nancy</i>	Middle <i>Jane</i>	Last <i>Hockersmith</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <i>No</i>	16b. SOCIAL SECURITY NO. <i>229-60-6524-T</i>	17. INFORMANT <i>L. L. Davis,</i>	1601 Glenhallow Ave., Wheaton, Md. 20902		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis</i> YRS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>334 X</i>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cerebral Arteriosclerosis. Chronic Pyelonephritis</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>
22a. I certify that (I) (this hospital) attended the deceased from <i>6/2</i> , 19 <i>68</i> , to <i>9/18</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6/8</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>R. T. Benack MD</i>	ATTENDING DEGREE <input type="checkbox"/> PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>9/18/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>R. T. Benack MD</i>	22e. ADDRESS <i>4115 Colie Drive, Wheaton, MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9/21/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mount Oliver Cemetery</i>	23d. LOCATION (City or Town) <i>Frederick-Frederick-Maryland</i>	(County) <i></i>	(State) <i></i>
24. FUNERAL DIRECTOR <i>Frank B. Smith Jr.</i>	ADDRESS <i>M. R. Etchison & Son, Frederick, Md. 21701</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE SEP 23 1968	

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

11. 12. 13. 14. 15. 16. 17. 18. 19. 20.

21. 22. 23. 24. 25. 26. 27. 28. 29. 30.

31

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13145

CERTIFICATE OF DEATH

13153

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First WILLIAM	Middle HOWARD	Last GOTTLIEB	2a. DATE OF DEATH Month SEPTEMBER Day 25, 1968 Year	2b. HOUR 4:30 P.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 11-17-1896		6. AGE (in years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH CHEVY CHASE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 19 QUINCY STREET		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Board Chairman		12b. KIND OF BUSINESS OR INDUSTRY Contracting
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN CHEVY CHASE	13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 19 QUINCY STREET	
14. FATHER'S NAME William	First Henry	Middle Gottlieb	15. MOTHER'S MAIDEN NAME Nellie	Middle Chase	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes	16b. SOCIAL SECURITY NO. 111-11-1111	17. INFORMANT Mrs. Louise D. Gottlieb, Wife, same as #13	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 162X None					
19a. MEDICAL CERTIFICATE ON DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 1, 1949</u> , to <u>SEPT 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Thomas S. Sappington</u>	M.D. DEGREE	ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9/25/68
22d. PHYSICIAN'S NAME (Type) THOMAS S. SAPPINGTON, M.D.	22e. ADDRESS 2233 WISC. AVE., N.W., WASHINGTON, D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-27-1968	23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery	23d. LOCATION (City or Town) Washington, D.C.	(County)	(State)
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016	ADDRESS 5130 Wisc. Ave. N.W., Wash., D.C., 20016	25a. REC'D BY REGISTRAR DATE SEP 30 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

13142 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13154

1 DECEASED NAME (Type or Print)			First GUY	Middle RUSSELL	Last HAINES	2a. DATE KNOWN OF ESTI. DEATH MATED	Month <input checked="" type="checkbox"/> Sept	Day <input type="checkbox"/> 24	Year <input type="checkbox"/> 68	2b. HOUR <input type="checkbox"/> 3P M					
3 SEX Male	4 RACE White	S. DATE OF BIRTH 1/28/03	6 AGE (In years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURLS MIN. 0	2c. DATE PRONOUNCED DEAD Month 9	Day 24	Year 68	2d. HOUR <input type="checkbox"/> 3P M					
7a. BIRTHPLACE (State or foreign country) West Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery									
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) carpenter			12b. KIND OF BUSINESS OR INDUSTRY construction							
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.	13b. CITY OR TOWN Pr. Georges	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3499 Fort Meade Rd.												
14. FATHER'S NAME Charles Page	Middle Haines	15. MOTHER'S MAIDEN NAME Johns	First Shawn	Middle Shawn	Last Shawn										
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes, 18 yr.	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17. INFORMANT Wife, Gladys	ADDRESS 3499 Ft. Meade Rd. Laurel, Md.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4111 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary insufficiency, acute years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden													
(Conditions, if any, wh ch gave rise to immediate cause (a). stating the underlying cause lost.)		DUE TO, OR AS A CONSEQUENCE OF (c) Coronary atherosclerosis, severe years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE John S. Bell		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 9/26/68								
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE 9-28-68	23c. NAME OF CEMETERY OR CREMATORIUM Meadow Point			23d. LOCATION (City or Town) Layton W Virginia		(County)		(State)						
24. FUNERAL DIRECTOR Danaelion Funeral Home Laurel Md	ADDRESS	25a. REC'D BY REGISTRAR SEP 30 1968			25b. REGISTRAR'S SIGNATURE Charles Judge										
VR A15ME (5) 10M REV 1/68															

15

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13143

CERTIFICATE OF DEATH

13155

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2a DATE OF DEATH Sept Month 26 Day 68 Year	2b HOUR 9:45 AM
3. SEX Female	4 RACE W	5 DATE OF BIRTH 5/31/1880		6 AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Canada	7b. CITIZEN OF WHAT COUNTRY? U. S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Wheaton	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wheaton Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13b. COUNTY Montgomery	13c CITY OR TOWN Bethesda	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 5000 Westpath Terrace	
14. FATHER'S NAME William Leonard	15. MOTHER'S MAIDEN NAME Celia Halliday				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 578-68-6817	17 INFORMANT Son Leonard C. Hall	Address Same as Item 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>(b) ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min 6 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1965</u> to <u>Sept 26 1968</u> , that (I) (we) last saw the deceased alive on <u>24 Sept 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>WALTER E. GOOZIL</u>		22c. DATE SIGNED 22d. PHYSICIAN'S NAME (Type) WALTER E. GOOZIL			
230. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-28-68	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Mem.Cem.	23d. LOCATION (City or Town) Annapolis, Maryland	(County) Maryland	(State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland	ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland	25a. REC'D BY REGISTRAR DATE OCT 2 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

13144

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

13156

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First <i>Joseph</i>	Middle <i>N.M.N.</i>	Last <i>Halpert</i>	2a. DATE OF DEATH Month <i>9</i>	Day <i>27</i>	Year <i>1968</i>	2b. HOUR <i>4:45 PM</i>
3. SEX <i>Male</i>	4 RACE <i>Caucasian</i>	5. DATE OF BIRTH <i>October 3-1889</i>		6. AGE (In years last birthday) <i>78 yrs.</i>		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>POLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>America</i>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery, Md</i>				
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. San. + Hospt.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Merchandise</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>GROCERY</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE <i>MARYLAND</i>	13b. COUNTY <i>PRINCE GEORGE'S</i>	13c. CITY OR TOWN <i>Adelphi</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>8133 15th Avenue</i>			
14. FATHER'S NAME First <i>Jacob</i>	Middle <i>Halpert</i>	15. MOTHER'S MAIDEN NAME First <i>Esther</i>	Middle <i>Unknown?</i>		Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>579-24-7582</i>	17. INFORMANT <i>WASH. SAN + HOSPT. MEDICAL RECORDS</i>		Address <i>210 DAYS</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)							
PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <i>BRONCHIAL PNEUMONIA & SEPTICEMIA</i>							
471X DUE TO, OR AS A CONSEQUENCE OF (b) <i>BRONCHIECTASIS - B</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) <i>CHRONIC BRONCHIOSIS</i> 5-6 yrs last							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>CARDIOMEGALY, ALCOHOLIC SCLEROSIS, HEREDITARY SCLEROSIS</i>							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, name medical examiner)	21b. TIME OF INJURY HOUR A.M. <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year P.M. <input type="checkbox"/> 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <i>68</i>	City or Town <i>BETHESDA</i>	County <i>MONTGOMERY</i>	State <i>MARYLAND</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>9/28/68</i> , to <i>9/29/68</i> , 1968, that (I) (we) last saw the deceased alive on <i>9/28/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Naresh Deo</i>							
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS <i>10320 32nd Street, MD</i>	22e. DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22f. DATE SIGNED <i>9/27/68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9/29/68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Epworth Cemetery</i>	23d. LOCATION (City or Town) <i>Holtsville</i>	(County) <i>Long Island</i>	(State) <i>NY</i>		
24. FUNERAL DIRECTOR <i>Goldberg Funeral Home</i>	ADDRESS <i>4277 9th St</i>	25a. RECD BY REGISTRAR DATE <i>OCT 2 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 30M REV.							



13145

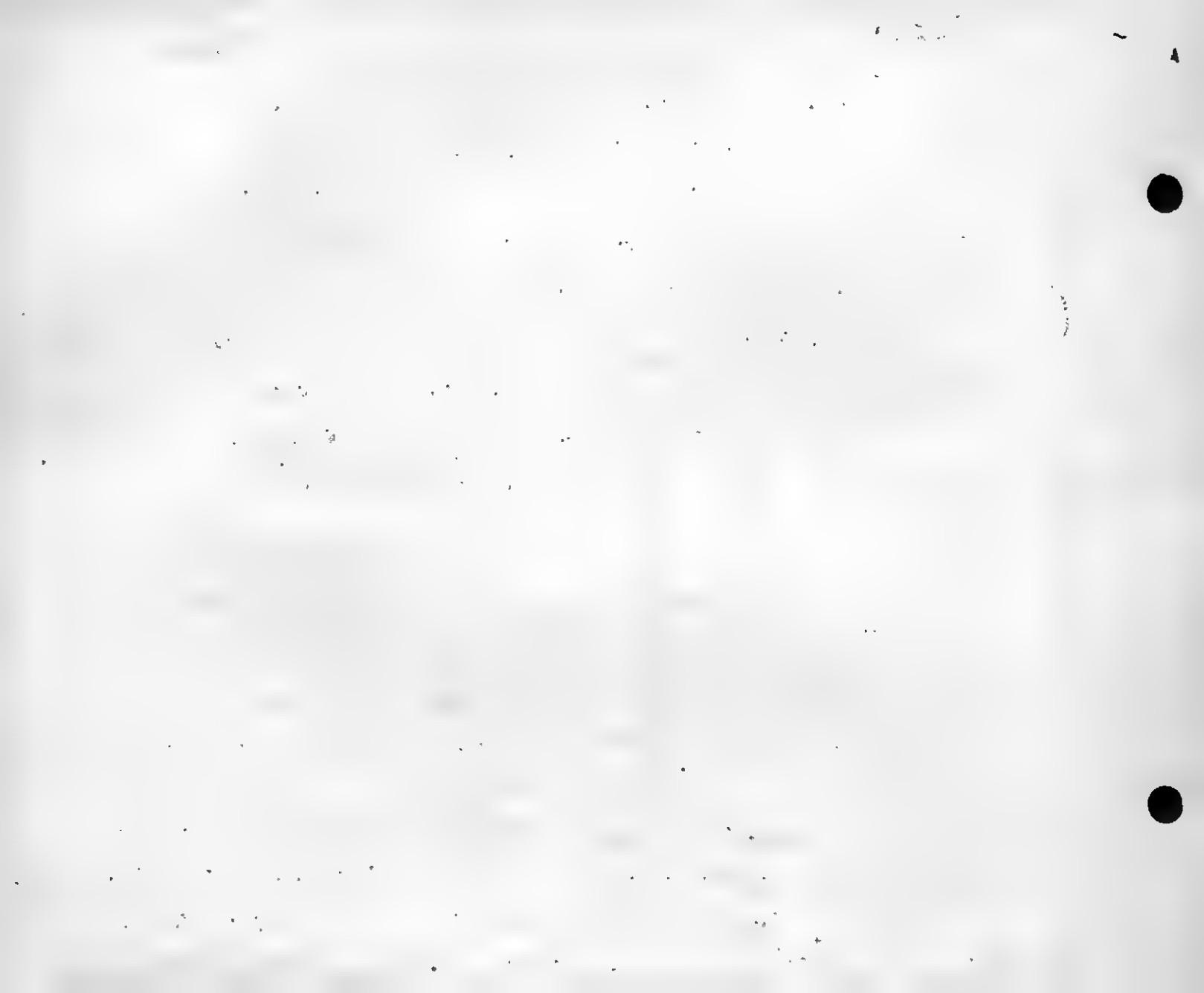
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13157

1. DECEASED NAME (Type or print)			First James	Middle C.	Last HANKEN	2a. DATE OF DEATH Month Sept. 26 Day 68 Year 68	2b. HOUR 210 P.M.		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH August 25, 1968		6. AGE (In years last birthday) 32 YRS.	7. IF UNDER 1 YEAR MONTHS 32 DAYS 00	8. IF UNDER 24 HRS. HOURS 00 MIN. 00	
7a. BIRTHPLACE (State or foreign country) Patuxent River Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most working life, even if retired.) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Dameron		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER - Star Route		
14. FATHER'S NAME First Richard S. Hanken		Middle	Last	15. MOTHER'S MAIDEN NAME First Trudy		Middle	Last Meadows		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown)		16b. SOCIAL SECURITY NO N/A		17. INFORMANT Richard S. Hanken, Dameron, Maryland		Address			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease: tricuspid atresia; transposition APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF of great vessels; coarctation of aorta; status Conditions, if any, which gave post surgical exploration rise to immediate cause (a). stating the <u>underlying cause</u> last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)</p>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION 26 Sept. 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Congenital heart disease		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from Sept. 9, 1968, to Sept. 26, 1968, that (I) (we) last saw the deceased alive on Sept. 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE 		22c. DATE SIGNED Sept. 27, 1968							
22d. PHYSICIAN'S NAME (Type) William R. Hix, M. D.		22e. ADDRESS Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/30/68		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) Arlington, Virginia		(County)	(State)
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.		ADDRESS		25a. REC'D BY REGISTRAR OCT 2 1968		25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the inmate be executed within 24 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, ages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Marcella</i>	Middle <i>M.</i>	Lost <i>Harp</i>	2a. DATE OF DEATH Month <i>Sept.</i>	Year <i>1968</i>	2b. HOUR <i>11:00 P.M.</i>	
3. SEX <i>Female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>1/22/16</i>		6. AGE (in years last birthday) <i>52 yrs.</i>	F. UNDER MONTHS <i>3</i>	YEAR DAYS <i>60</i>	I. F. UNDER 24 HRS HOURS <i>14</i>
7a. BIRTHPLACE (State or foreign country) <i>MINNA.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		Md		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>FAA, NEWS REPORTER OS GOUT</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>R.D. & R. REVENGE</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Reside before admission) STATE <i>Md.</i>	13c. CITY OR TOWN <i>SILVER SPRING</i>	13d. INSIDE CITY LIMIT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>11507 RIGNOLD DR</i>				
14. FATHER'S NAME First <i>?</i>	Middle <i>MARCOULLIER</i>	Lost <i>ROSE</i>	15. MOTHER'S MAIDEN NAME First <i>ROSE</i>	Middle <i>?</i>	Lost <i>?</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>UNKNOWN</i>	17. INFORMANT <i>MICHELE-R-DONNING</i>	Address <i>Bozeman</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>SEVERAL YEARS</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC BREAST CARCINOMA</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>17</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>AUG 31, 1968</i> , to <i>SEP. 1, 1968</i> , that (I) (we) last saw the deceased alive on <i>SEP. 1, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Roberto Daddario M.D.</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>9/2/68</i>		
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <i>5413 CEDAR LANE BETHESDA</i>						
23a. BURIAL CREMATION, REMOVAL (Specify) <i>CREMATION</i>	23b. DATE <i>9-3-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>FT. LINCOLN CREMATORIAL</i>	23d. LOCATION (City or Town) <i>COLEMAR MANOR</i>	(County) <i>M.D.</i>	(State)		
24. FUNERAL DIRECTOR <i>W.W. JONES CO. INC.</i>	ADDRESS <i>14100 Georgia St.</i>	25a. REC'D BY REGISTRAR <i>SEP 10 1968</i>	25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 20 Film

13147

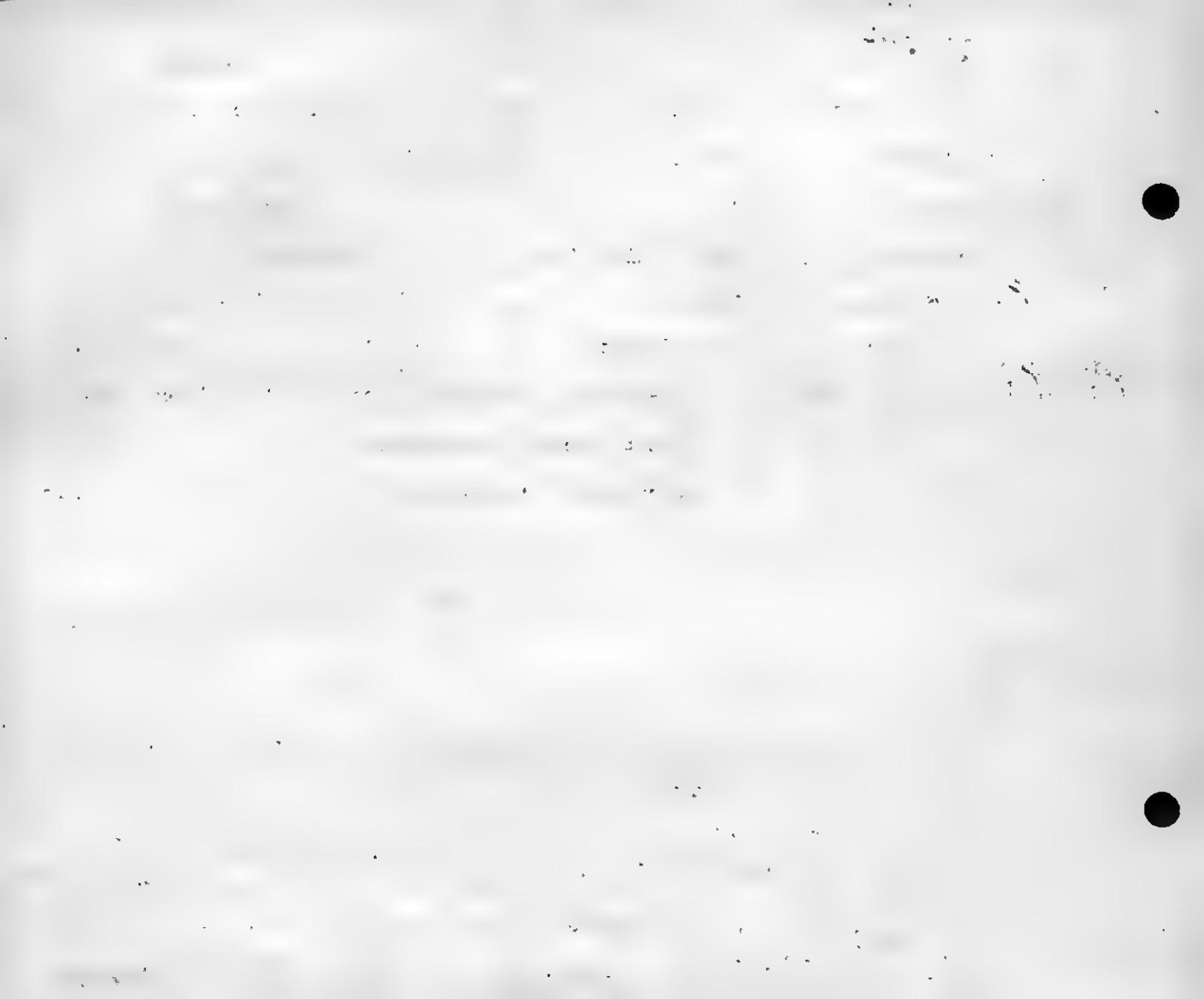
CERTIFICATE OF DEATH

13159

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First Mary	Middle Adele	Lost Harper	2a. DATE OF DEATH Month September	Day 12	Year 1968	2b. HOUR 7:00 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH 5 April 1925		6. AGE (In years last birthday) 43	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF HOURS 0
7a. BIRTHPLACE (State or foreign country) Louisiana	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia	13b. COUNTY Fairfax	13c. CITY OR TOWN Fairfax	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9907 Colony Road			
14. FATHER'S NAME First Homer	Middle Garrett	15. MOTHER'S MAIDEN NAME First Hattie	Middle Cutrer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown Yes	16b. SOCIAL SECURITY NO. 1950-51	17. INFORMANT Bethesda, Maryland 20014 The Medical Records, The Clinical Center,	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Sepsis, Pneumonitis DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) 157.9 Carcinoma of the Pancreas (b) 5 months DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 15.1							
19a. DATE OF OPERATION 15.1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 22 August, 1968 , to 12 Sept., 1968 , that (I) (we) last saw the deceased alive on 12 September 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. Bryan Neel, M.D.		DEGREE MD	ATTENDING PHYS MD	MED DIRECTOR MD	STAFF PHYS MD	22c. DATE SIGNED 12 September 1968	
22d. PHYSICIAN'S NAME (Type) H. Bryan Neel III, M.D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept 16, 68	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem		23d. LOCATION (City or Town) Arlington, Va.	(County)	(State)
24. FUNERAL DIRECTOR Charles H. Grindell		ADDRESS Fairfax, Va.	25a. REC'D. BY REGISTRAR SEP 16 1968		25b. REGISTRAR'S SIGNATURE Charles Grindell		
Everly Funeral Home			DATE				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. In case of delay, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PR 3 (page 5) may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
13148 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13160

1 DECEASED NAME (Type or Print)	First Millicent	Middle A.	Lost Harris	2a DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	Month 9	Day 25	Year 1968	2b HOUR 7:30 A.M.		
3 SEX F	4 RACE W	S. DATE OF BIRTH 6/9/1876	6 AGE (In years last birthday) 92 yrs	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD Month Sept.	Day 25	Year 1968	2d HOUR 7:30 P.M.
7a BIRTHPLACE (State or foreign country) N.Y.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH MONTGOMERY Co. Md							
10. CITY OR TOWN OF DEATH Kensington	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens	12a USUAL OCCUPATION (Kind of work done during most of working life, even if ret'd.) Restaurant	12b KIND OF BUSINESS OR INDUSTRY RESTAURANT							
13a USUAL RESIDENCE (Where deceased lived, if institu- tional, residence before admission) STATE Washington D.C.	13b COUNTY D.C.	13c CITY OR TOWN Washington D.C.	13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 4702 Warren St., N.W.						
14 FATHER'S NAME First Unknown	Middle Unknown	Lost Unknown	15. MOTHER'S MAIDEN NAME First Edith unknown	Middle Unknown	Lost Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None			16b SOCIAL SECURITY NO. 88-10-1234	17. INFORMANT MISS. EDITH J. GOODE, 4000 CATH. AVE. N.W., DC	ADDRESS FRIEND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vessel thrombosis Due to, or as a consequence of (b) Cerebral arteriosclerosis Due to, or as a consequence of (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture hip right										
19a. DATE OF OPERATION 8-23-1968	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture right hip	20. AUTOPSY? NO <input checked="" type="checkbox"/>								
19c. MEDICAL CERTIFICATION EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH Slipped from chair to floor fracturing	21b. TIME OF INJURY Month, Day, Year HOUR Aug 19 1968 10:00 P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Slipped from chair to floor fracturing	21d. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Residence	21e. LOCATION Street or P.O. F.D. No 3009 McCormay, Kensington, Md.	21f. CITY OR TOWN Kensington Gardens	21g. COUNTY OR PARISH Montgomery County, Md.				
21h. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21i. DEPUTY MEDICAL EXAMINER NAME (Type) John S. Bell	22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	22b. DATE SIGNED Sept 23, 1968							
EXAMINER'S NAME (Type)	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 9-27-1968	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	23d. LOCATION (City or Town) Suitland, Prince Georges Co.	(County) Prince Georges Co.	(State) Md.					
24. FUNERAL DIRECTOR Joseph Lawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016	ADDRESS	25a. REG'D BY REGISTRAR SEP 30 1968	25b. REGISTRAR'S SIGNATURE Charles Judge							



13149

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please return carbon paper [] and 2 [] to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)		First <i>Jennifer</i>	Middle <i>Lynn</i>	Last <i>HARVEL</i>	2a. DATE OF DEATH Month <i>9</i>	Doy <i>17</i>	Year <i>68</i>	2b. HOUR <i>11:48 A.M.</i>			
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>9/17/68</i>		6. AGE (In years lost birthday) YRS. <i>12</i>		IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	AM. <i>12</i>
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY CO.</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>SUBURBAN</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Rockville</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>13002 CRADKSTON LANE</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <i>MARYLAND</i>		13c. CITY OR TOWN <i>MONTGOMERY</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>13002 CRADKSTON LANE</i>					
14. FATHER'S NAME First <i>DENNIS</i>		Middle <i>HARVEL</i>	Lost	15. MOTHER'S MAIDEN NAME First <i>JUDITH</i>		Middle <i>E</i>	Lost <i>JORDAN</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Dennis Harvel - FATHER</i>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1964</i> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <i>atalee Farris</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonia</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <i>10/20/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>9/17/68</i> , to <i>9/17/68</i> , that (I) (we) last saw the deceased alive on <i>9/17/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>RICHARD H. FISCHER</i>		22c. ADDRESS <i>50 W. Edmonston Drive Rockville, Maryland</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <i>9/17/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>RICHARD H. FISCHER</i>		22e. ADDRESS <i>50 W. Edmonston Drive Rockville, Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-21-68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Darnestown Cemetery</i>		23d. LOCATION (City or Town) <i>Darnestown, Maryland</i>		(County)		(State)	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>SEP 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
13162

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1	13150					20. DATE OF DEATH Month <i>Sept</i>	Year <i>1968</i>	2b. HOUR <i>1 PM M</i>		
1 DECEASED NAME (Type or print) <i>ROBERT S. HATCH</i>				Middle <i>S.</i>	Lost <input checked="" type="checkbox"/>	20. DATE OF DEATH Month <i>Sept</i>	Year <i>1968</i>	2b. HOUR <i>1 PM M</i>		
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>7/6/07</i>		6. AGE (In years last birthday) <i>61 yrs.</i>		IF UNDER 1 YEAR MONTHS <input type="checkbox"/>	IF UNDER 24 HRS. DAYS <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i>				
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>SUBURBAN</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>ATTORNEY</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>MARINE CORPS</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>Cherry Chase</i>		13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>8711 BRIERLY COURT</i>		
14. FATHER'S NAME First <i>FRANK</i>		Middle <i>J.</i>	Last <i>HATCH</i>	15. MOTHER'S MAIDEN NAME First <i>ORA LOWELL</i>		Middle <input type="checkbox"/>	Last <input type="checkbox"/>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>598-38-8218</i>		17. INFORMANT <i>ZETTA A. WIFE</i>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <i>Myocardial infarction, old & recent, left ventricle wall & interventricular septum, diffuse</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>diffuse</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Severe coronary arteriosclerosis & coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>#301</i>										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <input type="checkbox"/> P.M. Month Day Year <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>1958</i> , 19 <i>1</i> , to <i>date</i> , 19 <i>1</i> , that (I) (we) last saw the deceased alive on <i>9 Sept 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED <i>9/11/68</i>
22d. PHYSICIAN'S NAME (Type) <i>John S. Bell</i>		DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS	22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-14-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) <i>Rockville, Montgomery Co., Md.</i>		(County) <i>Montgomery Co., Md.</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. U.W., Wash., D.C., 20016</i>		ADDRESS		25a. REC'D. BY REGISTRAR DATE <i>SEP 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. G</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13151

13163

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE New York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Heaton		c. LENGTH OF STAY IN 1b 19 Days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Island City	
d. NAME OF HOSPITAL (If not in hospital, give street address) UNIVERSITY NURSING HOME		e. STREET ADDRESS 4013 Vernon Boulevard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Oscar L. Hazzard		First	Middle	Lost	4. DATE OF DEATH Sept. 30, 1968
S. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1895	9. AGE (in years last birthday) 72 yrs.	Month Sept. Day 30 Year 19

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Worker	10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't	11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13. FATHER'S NAME George W. Hazzard	14. MOTHER'S MAIDEN NAME Mary Elizabeth Morehouse		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)	16. SOCIAL SECURITY NO. 118-36-0954	17. INFORMANT Mrs. Margaret Washington	Address 3112 19th St NW Wash., D. C.

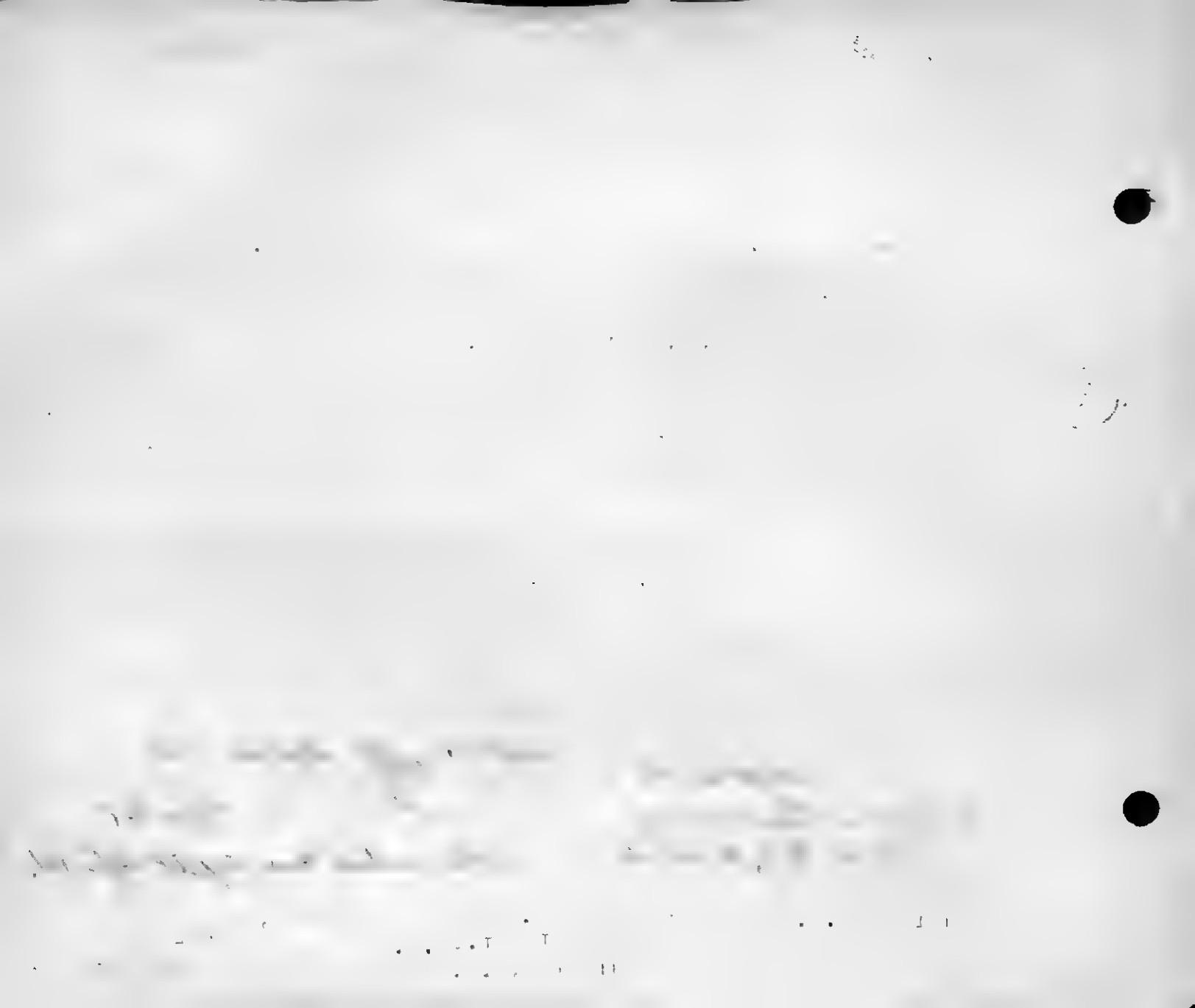
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1 hour
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		Occurrence of hypo Int, Carotid artery
(b)		4 months
(c)		Anterior cerebral artery vascular disease?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
4221		

20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 11, 1968, to Sept. 30, 1968, that (I) (we) last saw the deceased alive on Sept. 30, 1968, and that death occurred at 12 PM, from the causes and on the date stated above.

22a. SIGNATURE William Brannin	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/30/68
22c. PHYSICIAN'S NAME (Type) WM. BRANNIN	22d. ADDRESS 6050 Central Ave Capitol Hill, D.C.	

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10.4.68	23c. NAME OF CEMETERY OR CREMATORIAL LINCOLN MEM. CEM	23d. LOCATION (City, town, or county) SUITLAND, MARY
24. FUNERAL DIRECTOR'S SIGNATURE Robert G. Guine	ADDRESS 1820 9TH ST., N.W. WASHINGTON, D.C.	N.O. REC'D BY REGISTRAR NO. 8 DATE OCT 2 1968	25b. REGISTRY SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13152

13164

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month	Doy	Year	2b. HOUR 9 AM M			
Frances	M	Heil		Sept	21	1968				
3. SEX	4 RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)							
Female	White	3/25/1927	71 YRS.	F UNDER 1 YEAR	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH						
Wash DC	USA			Montgomery						
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda	Suburban	Secretary			Retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER							
MD	Mont	Bethesda	7828 Shadydale Dr.							
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
Matthew		Rawlings		Anne			Flanagan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Husband	Address						
		Joseph B. Heil, Sr.	Same as Item 13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 4120 CARDIAC ARREST								SUDDEN		
Conditions if any, which gave rise to immediate cause (o), stating the underlying cause (b) CORONARY SCLEROSIS								5 YEARS		
(c) ARTERIOSCLEROSIS, GENERAL								10 YEARS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
<input type="checkbox"/> D CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that (I) (this hospital) attended the deceased from APRIL 19, 1962, to Sept 21, 1968, that (I) (we) last saw the deceased alive on SEP. 20 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE Robert G. Angle		DEGREE	ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-22-68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22e. ADDRESS						
ROBERT G. ANGLE		5009 Del Ray Ave. Bethesda, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)	(County)	(State)			
Burial		9-24-68	Mt. Olivet Cemetery		Washington, D. C.					
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D BY REGISTRAR		25b. REG STRR'S SIGNATURE					
ROBERT A. PUMPHREY, Bethesda, Maryland			DATE SEP 27 1968		Charles Judge					



Item 18²-Film 406 11-19-68 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13153

CERTIFICATE OF DEATH

13165

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper [page 1] and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR 7:10 PM
Hankle, Harry Lynn HENKLE				Sept 15, 1968	
3. SEX m	4. RACE Cau	S. DATE OF BIRTH 1800	6. AGE (in years) last birthday 77 yrs.	7. UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Plimoth Oregon USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Heaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home Colonial U.S. Army			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sgt.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Brentsville, Md.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 15203 Blackburn Rd.	
14. FATHER'S NAME CHAS	First	Middle	Last	15. MOTHER'S MAIDEN NAME MINNIE	16. KIND OF BUSINESS OR INDUSTRY Gov't.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16b. SOCIAL SECURITY NO WWII 217-52-6412		17. INFORMANT Est' at Herble 15203 Blackburn Rd.	Address Stephville, Md.
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of pharynx 149X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause lost					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1964					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 14xx Hypertension					
19a. DATE OF OPERATION 14xx		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from July 1968 to 15 Sept 1968, that (I) (we) last saw the deceased alive on 15 Sept 1968, and that in my (<u>my</u>) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Walter E. Goozh MD		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 1968	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS WALTER E. GOOZH MD 2309 SHOREFIELD RD WHEATON MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 9-17-1968	23c. NAME OF CEMETERY OR CREMATORIUM St. John Cemetery	23d. LOCATION (City or Town) Stephville, Md.		(County) (State)
24. FUNERAL DIRECTOR Judge J.W. Lee	ADDRESS 15203 Blackburn Rd., Ste. 100, Silver Spring, Md.	25a. REC'D BY REGISTRAR SFP 20 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13154		MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13166		
1. DECEASED NAME (Type or Print)		First		Middle		Lost		20. DATE KNOWN OF ESTI- DEATH MADE		Month	Day	Year	2b HOUR	
GEORGE		G.		HERMAN				<input checked="" type="checkbox"/>		9	13	1968	68515A	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MN		2c. DATE PRONOUNCED DEAD Month Day Year		2d HOUR				
Male	White	26 Jan 1893		75 yrs				Sept 13 1968		15 AM				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Montgomery						
Illinois		U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done or gross most of working time even if part time)		12b. KIND OF BUSINESS OR INDUSTRY								
Bethesda		5927 Conway Rd.		Ret. Officer & P.P.		U.S. Navy								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER								
STATE Md.		Montgomery Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5927 Conway Rd.,								
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last					
		Emil		Hermann	Pauline				Schiettlinger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		5927 ADDRESS		Conway Rd.						
Yes 1918-1949		213-38-4441		Mrs. Grace E. Herman, Bethesda, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary insufficiency - acute				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		acute						
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		Cardiovascular disease		years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY?								
19c. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		John G. Ball		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED				
EXAMINER'S NAME (Type)		John G. Ball								9/13/68				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)				
Burial		9/17/68		Highland City Cemetery, Highland, Madison, Ill.										
24. FUNERAL DIRECTOR		ADDRESS		7557 Wisconsin Ave		25a. REC'D BY REGISTRAR		25b. REG. STAR'S SIGNATURE						
ROBERT A. PUMPHREY, Bethesda, Maryland						DATE SEP 18 1968		j Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13155

13167

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR Min.
ELIZABETH MELLOR HESLOP.				SEPT 23 1968	11 A.M.
3. SEX	4 RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. IE UNDER 1 YEAR MONTHS DAYS HOURS MIN
FEMALE	WHITE	August 31 - 1917		51 YRS	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	
HAGERSTOWN Md	U.S.A.			Montgomery	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)	
BETHESDA	Suburban			CLEER	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	12b. KIND OF BUSINESS OR INDUSTRY	
MARYLAND	MONTGOMERY BETHESDA	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7812 STRAFORD RD.	GEICO	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MARK			MELLOR	LAST MELL - LETTIES	IN 5 MONTHS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. (IMMEDIATE CAUSE (a))		
NO	***	GALE HESLOP (husband)	CORONARY THROMBOSIS		
DUE TO, OR AS A CONSEQUENCE OF (b) HYPER TENSION			5 YRS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (We) attended the deceased from JUN 1950, to SEP 1968, that (I) (We) last saw the deceased alive on 9/23 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dr. L. G. DONOVAN MD</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9/24/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 8218 WISCONSIN AVE BETHESDA MD			
23a. BURIAL, CREMATION, REMOVAL(Specify)	23b. DATE Cremation 9/27/68	23c. NAME OF CEMETERY OR CREMATORIALy	23d. LOCATION (City or Town) Suitland, Pr. Geo. Co. Md	(County)	(State)
24. FUNERAL DIRECTOR	7557 ADDRESS ROBERT A. PUMPIREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE SEP 27 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13156

13168

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Mary C. Hicks.	Middle	Lost	2a. DATE OF DEATH Month Sept. 24 1968	Year	2b. HOUR 5 PM	
3. SEX Female	4. RACE white	5. DATE OF BIRTH 5-16-84	6. AGE (In years last birthday) 84 yrs	F UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md. 11/1915.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY 5am-8pm housework				
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.	13c. CITY OR TOWN Montgomery Bethesda	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 9700 - Singleton Dr				
14. FATHER'S NAME First Wm. Edward Connally	Middle	15. MOTHER'S MAIDEN NAME First Mary	Middle	16. SOCIAL SECURITY NO. 50746-4076	INFORMANT Address Mary C. Sullivan	17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) due to, or as a consequence of (c)	ACUTE MYELOGENOUS LEUKEMIA						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GENERALIZED ARTERIOSCLEROSIS							
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 19, 1968, to SEPT. 24, 1968, that (I) (we) last saw the deceased alive on SEPT. 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph D. Connor, M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED SEPT. 24, 1968			
22d. PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR	22e. ADDRESS 9420 20th GEORGETOWN RD. BETHESDA						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-27-68	23c. NAME OF CEMETERY OR CREMATORIAL South Side Cemetery	23d. LOCATION (City or Town) Pittsburgh, Penna	(County)	(State)		
24. FUNERAL DIRECTOR Robert A. Pumphrey	ADDRESS 7557 Wisconsin Ave	25a. REC'D BY REGISTRAR Beth. Md	25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If "pending" in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

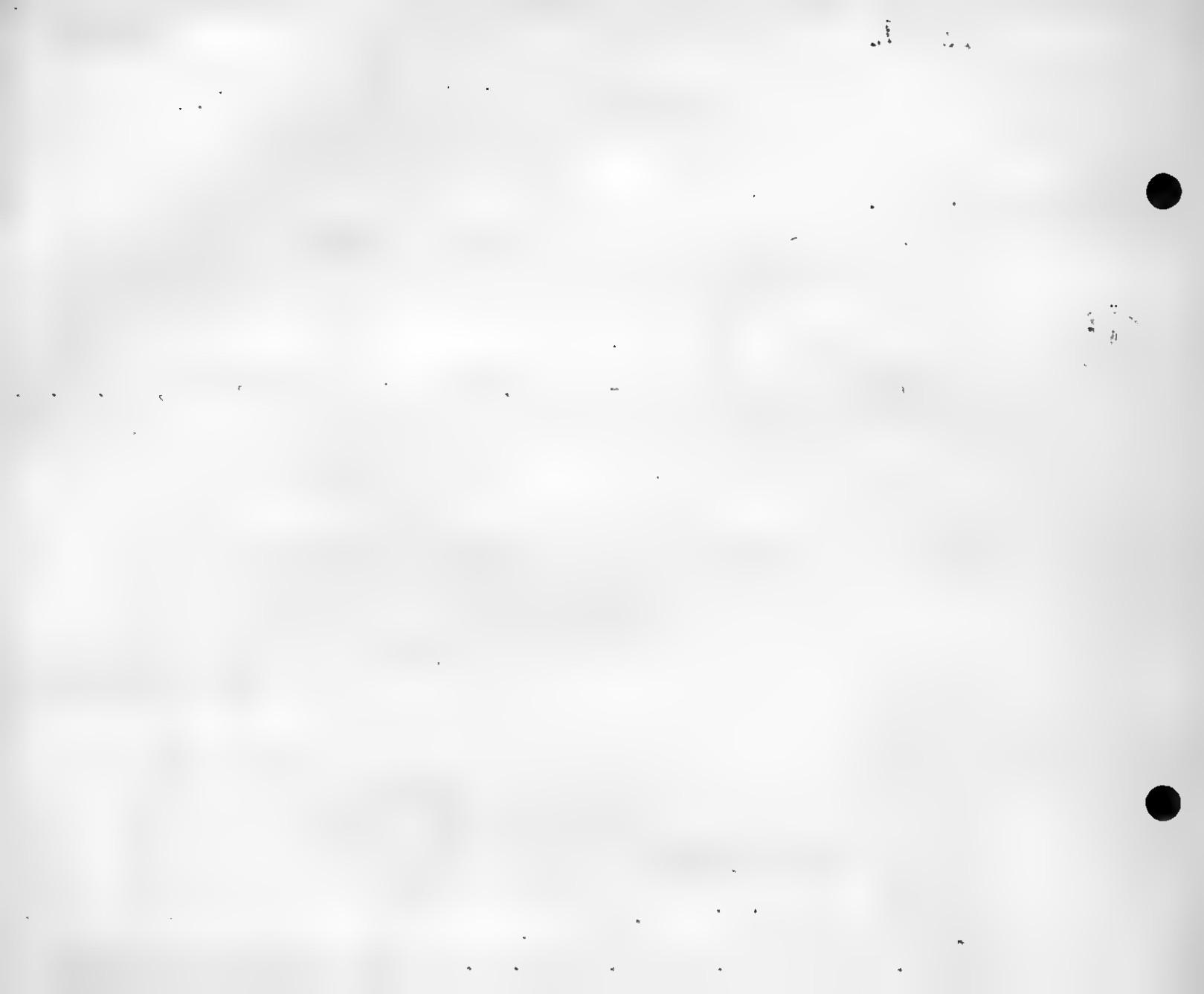
13157

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13169

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR
<i>Rufus Lee</i>					<i>Hill</i>	<input checked="" type="checkbox"/> Sept 29	1968	10	A.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	7c DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR	
<i>M.</i>	<i>W.</i>	<i>7/18/1908</i>	<i>60 YRS</i>			<i>Sept. 29</i>			<i>10 A.M.</i>	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH				
<i>Washington DC</i>		<i>U.S.A.</i>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>Montgomery</i>				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
<i>Silver Spring</i>			<i>8306 Draper Lane</i>			<i>Salesman</i>			<i>Insurance</i>	
13a USUAL RESIDENCE (Where deceased resided, if instit on Residence before admission) STATE			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER	
<i>Md.</i>			<i>Montgomery Silver Spring</i>			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			<i>8306 Draper Lane</i>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
<i>Rufus Lee Hill</i>			<i>Lotti Brown</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS	
<i>No</i>			<i>577-03-4848</i>			<i>Mrs. Jean Hill</i>			<i>8306 Draper Lane, Sil. Spr. Md.</i>	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Hemorrhage - Massive - Esophageal -</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <i>Esophagitis & Gastritis - acute & chronic -</i> 4 years.										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <i>Chronic Alcholism -</i> years.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
					<i>P.M. 19</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		<i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)		<i>John G. Ball</i>			22b. DATE SIGNED <i>Sept. 29, 1968</i>					
23a. BURIAL, CREMAT. ON, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town)		(County)	(State)
<i>Burial Carter Osten Carter</i>		<i>10-2-1968</i>		<i>St. John Episcopal Church</i>			<i>Beltsville, Prince Geo.</i>			
24. GENERAL EXAMINER		ADDRESS			25a. REC'D BY REG STRR		25b. REGISTRAR'S SIGNATURE			
<i>Warren E. Pumphrey, Inc.</i>		<i>8434 Ga. Ave. Sil. Spr.</i>			<i>OCT 2 1968</i>		<i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13158

13170

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
			Rosa	Barnes	Hilton	Month Sept. Day 22, Year 1968		6P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday) 72		IF UNDER 1 YEAR MONTHS	
Female		White		Jan. 9, 1896		YRS		IF UNDER 24 HRS DAYS	
7b. CITIZEN OF WHAT COUNTRY?		USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		HOURS	
7c. BIRTHPLACE (State or foreign country) Maryland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 26540 Ridge Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
10. CITY OR TOWN OF DEATH Damascus		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 26540 Ridge Rd.			
14. FATHER'S NAME Wm. Fillmore Lewis		15. MOTHER'S MAIDEN NAME Olive Mae Watkins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 213-58-3563		17. INFORMANT Mrs Brandon W. Duvall, Damascus, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Vascular Accident				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours?			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 443X		DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiovascular Disease with Hypertension				10 years.			
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Severe Diabetes Mellitus 12 years.									
19a. MEDICAL CERTIFICATION None		19b. DATE OF OPERATION None		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) No Injury					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) (was) attended the deceased from 1947, 19, to September 19, 1968, that (I) (was) lost saw the deceased alive on September 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.									
22b. SIGNATURE McKendree Boyer, M.D.		22c. DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED September 23, 1968		
22d. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.		22e. ADDRESS 9701 Church Street Damascus, Maryland.							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 25, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Bethesda Meth.		23d. LOCATION (City or Town) Browningsville, Md.			
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13171

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons - pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. DECEASED-NAME (Type or print)	First Willie	Middle Daniel	Last Holmes	2a. DATE OF DEATH Month September	Day 16	Year 1968	2b. HOUR 1:30AM
3. SEX Male	4 RACE Negro	5. DATE OF BIRTH July 17, 1954			6. AGE (in years last birthday) 14	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 0
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student			12b. KIND OF BUSINESS OR INDUSTRY --		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia	13b. COUNTY Chesapeake	13c. CITY OR TOWN Chesapeake	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 247 Dunn Street			
14. FATHER'S NAME First Theodore	Middle H.	Last Holmes, Sr.	15. MOTHER'S MAIDEN NAME First Mildred	Middle Coffee			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 20/0							
(b) Acute undifferentiated leukemia vs. lymphosarcoma 6 mos.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State 16
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 31, 1968 , to September 19, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 16, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE David H. Riddick, MD							
22c. DATE SIGNED 16 Sept. 1968							
22d. PHYSICIAN'S NAME (Type) David H. Riddick		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-20-68	23c. NAME OF CEMETERY OR CREMATORIAL Roosevelt Memorial Park		23d. LOCATION (City or Town) Norfolk, Virginia	(County)	(State)
24. FUNERAL DIRECTOR John T. Rhines Company Funeral Home 3015 12th Street, N.E.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 19 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

SC

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13160

CERTIFICATE OF DEATH

13172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Pearl	Middle (NMN)	Last Honig	2d. DATE OF DEATH Month September	Day 16 , 1968	Year 1968	2d. HOUR 3:30	
3. SEX female		4 RACE White	5. DATE OF BIRTH June 13, 1909		6 AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS 0 MONTHS		
7d. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? America	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Tokoma Park		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret.ret.) Housewife		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 11505 Yates Street
14. FATHER'S NAME First Morris		Middle Rudner	Last	15. MOTHER'S MAIDEN NAME First Lena					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO.		17. INFORMANT Patient's chart		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF Myocardial infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Coronary arteriosclerosis		(b) DUE TO, OR AS A CONSEQUENCE OF Coronary arteriosclerosis		(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 4/1/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 17, 1968 to Sept 16, 1968 , that (I) (we) last saw the deceased alive on Sept 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Boris Rabkin		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-16-68			
22d. PHYSICIAN'S NAME (Type) Boris Rabkin, M.D.		22e. ADDRESS 1019 University Blvd East Silver Spring							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 18, 1968		23c. NAME OF CEMETERY OR CREMATORIAL King David Memorial Garden		23d. LOCATION (City or Town) Falls Church, Virginia		(County) (State)	
24. FUNERAL DIRECTOR Donald M. Stein		ADDRESS 232 Carroll St., N.W. Wash., D.C.	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 19 1968		
Habens Memorial Funeral Home									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13173

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1	DECEASED NAME (Type or print)	First HELEN	Middle BRUCE	Last HORNER	2a. DATE OF DEATH SEPT Month / Day 68 Year 1316	2b. HOUR 4:50 PM			
3. SEX FEMALE	4 RACE CAUC.	5. DATE OF BIRTH JULY 8, 1880			6. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9 COUNTY OF DEATH MONTGOMERY						
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FAIRFIELD NURSING HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) N/A			12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13c. CITY OR TOWN MONTGOMERY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 10920 N HAMPSHIRE AVE						
14. FATHER'S NAME First WILLIAM	Middle MORRISON	Last	15 MOTHER'S MAIDEN NAME First HELEN AGNEW	Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown —	16b. SOCIAL SECURITY NO 213-56-1728	17. INFORMANT Frank Clark -	Address						
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4200						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR			
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis						42 S			
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral arteriosclerosis									
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) at work						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No 1015	City or Town 101		County 71	State 1968		
22a. I certify that (I) (this hospital) attended the deceased from 10/1/68 , to 19/10/68 , that (I) (we) last saw the deceased alive on 10/1/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R.T. Benack MD		ATTENDING PHYS. MD	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9/1/68				
22d. PHYSICIAN'S NAME (Type) R.T. Benack MD		22e. ADDRESS 4115 Colie Drive, Wheaton MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE SEPT 4, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Resbyterian Cemetery, Frederick, Md.	23d. LOCATION (City or Town) Frederick, Md.	(County) Jurisdiction Co. Md.	(State) MD.				
24. FUNERAL DIRECTOR Clarence E. Wilson, Emmitsburg, Md.	ADDRESS Emmitsburg, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13162

13174

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Susan	Middle JEANETTE	Lost HUESTIS	2a. DATE OF DEATH Month Sept.	Year 9 68	2b. HOUR P 6:10 M	
3 SEX Female	4 RACE Caucasian	S. DATE OF BIRTH August 19, 1968	5. AGE (In years last birthday) YRS. 21	6. IF UNDER 1 YEAR MONTHS 21	7. IF UNDER 24 HRS. DAYS 21	8. IF UNDER 24 HRS. HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) N/A	12b. KIND OF BUSINESS OR INDUSTRY N/A				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Virginia	13b. COUNTY Arlington	13c. CITY OR TOWN Arlington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2846 S. Abingdon St.			
14. FATHER'S NAME First John	Middle W.	Lost Huestis	15. MOTHER'S MAIDEN NAME First Barbara	Middle J.	Last Dorosh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No *****	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None	17. INFORMANT John W. Huestis, 2856 S. Abingdon St.	Arlington	Address Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease; pulmonary atresia '746 b DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7545							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from Aug. 20, 1968, to Sept. 9, 1968, that (I) (we) last saw the deceased alive on Sept. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did <input type="checkbox"/> view the body after death.							
22b. SIGNATURE B. Jay Bortz, M.D.		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Sept. 11, 1968		
22d. PHYSICIAN'S NAME (Type) NAME (Type) B. Jay Bortz, M.D.		22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/12/68	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery Arlington	23d. LOCATION (City or Town) Va.	(County)	(State)		
24. FUNERAL DIRECTOR Robert A. Pumphrey Home, 7557 Wisconsin Ave., Bethesda, Md.	ADDRESS Funeral	25a. REC'D BY REGISTRAR DATE SEP 16 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				

VIP

FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner Office along with form PMS-Page
5 may be retained for your files.

[Signature]
Health prior to burial, cremation, or removal, and in any event within 72 hours after death

13163 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13175

1. DECEASED NAME (Type or Print)		First <i>Gertrude</i>	Middle <i>IDA</i>	Last <i>Huet</i>	2a DATE KNOWN <input checked="" type="checkbox"/> EST. - <input type="checkbox"/> DEATH MATED	Month <i>Sept</i>	Day <i>21</i>	Year <i>1968</i>	2b H.O.J.R. <i>5 15 AM</i>
3 SEX <i>FEMALE</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>2-14-1922</i>	6 AGE (In years last birthday) <i>46</i>	7 MONTHS <i>YRS</i>	IF UNDER 1 YEAR <input type="checkbox"/> MONTHS	IF UNDER 24 HRS <input type="checkbox"/> DAYS	MIN. <i>00</i>	2c DATE PRONOUNCED DEAD Month <i>Sept</i>	2d HOUR <i>21</i>
7a. BIRTHPLACE (State or foreign country) <i>Bethesda, MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9 COUNTY OF DEATH <i>Montgomery</i>			
10 CITY OR TOWN OF DEATH <i>BETHESDA</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased resided before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Springfield</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>4314 Maher Rd.</i>			
14 FATHER'S NAME First <i>James</i>		Middle <i>B</i>	Last <i>Carter</i>	15. MOTHER'S MAIDEN NAME First <i>Alice</i>		Middle <i>Looney</i>	Last <i>[Signature - pending]</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO <i>620-38-1417</i>		17. INFORMANT Husband <i>PAUL H. Huet</i>		ADDRESS <i>4314 Maher Rd.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>41 hr.</i>
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>DIFFUSE Right CEREBRAL Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Rupture ANEURYSM At M. A. 20 K. Cerebralis/A.</i> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>[Signature]</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Ball</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>Sept 21, 1968</i>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL, M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county) <i>Montgomery Co. Md.</i>					
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9/24/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) <i>Frederick, Fred. Co. Md.</i>		(County) <i>Frederick</i>		(State) <i>MD</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	25a. REC'D BY REGISTRAR <i>DA SEP 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						
VR A15AB 10M REV 1/68									



13176

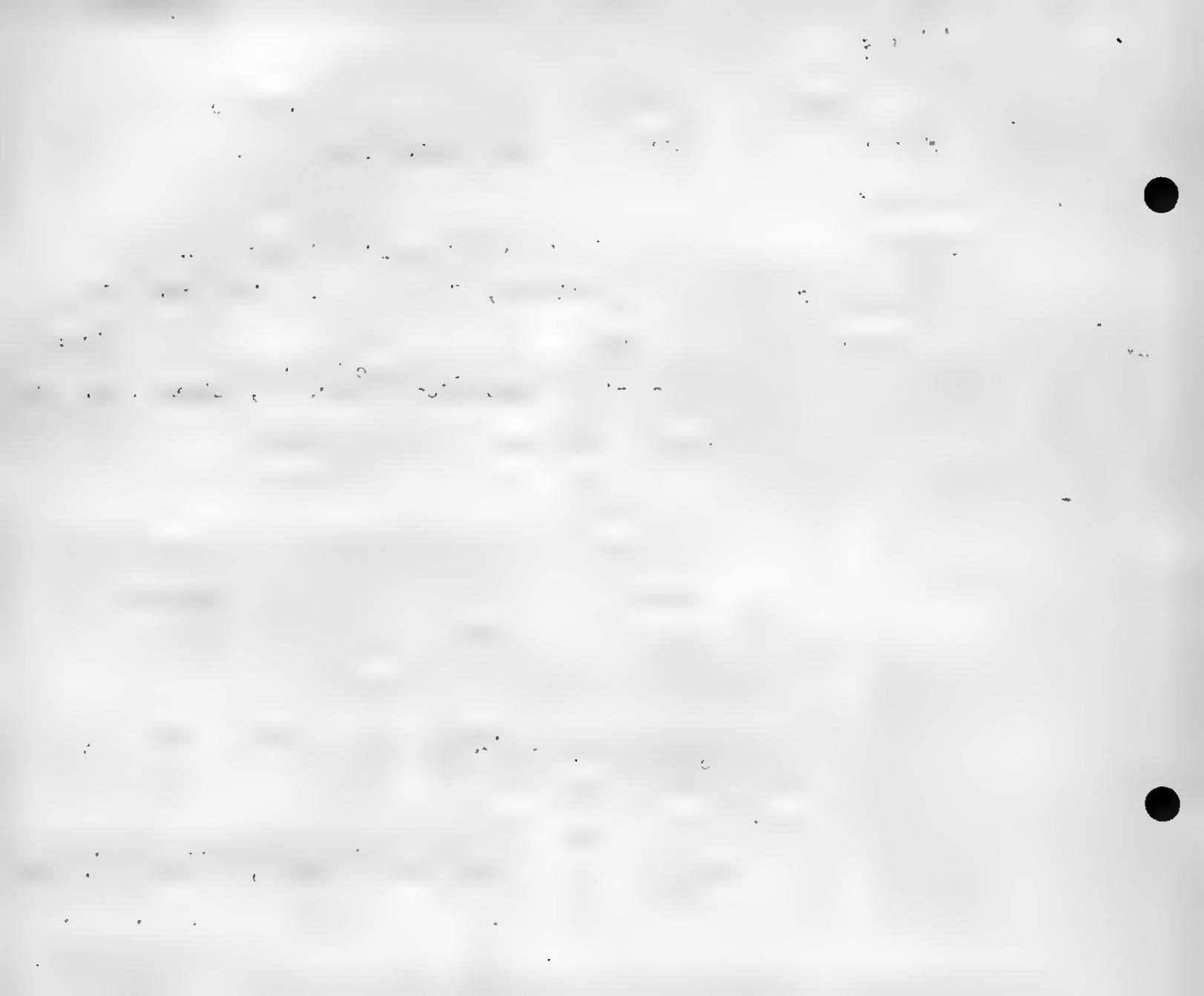
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **Page 1** and **2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Ruth	Middle Eleanor	Last Idol	2a. DATE OF DEATH Month September	Day 23	Year 1968	2b. HOUR 10:40
3. SEX Female		4 RACE White	5. DATE OF BIRTH 16 November 1911		6. AGE (In years lost birthday) 56		IF UNDER 1 YEAR MONTHS YRS.	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Bethesda	
		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Staff Assistant (ret.)		12b. KIND OF BUSINESS OR INDUSTRY Md		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Washington, D.C.		13b. COUNTY Washington, DC	13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 601 19th Street, NW		
14. FATHER'S NAME First Chase		Middle Idol	15. MOTHER'S MAIDEN NAME First Ruth		Middle Siewers	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 577-60-4416		17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Years		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic malignant Melanoma (Widespread) 1729 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. MEDICAL CERTIFICATION 17		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 25 August, 1968 , to 23 Sep, 1968 , that <input type="checkbox"/> (we) last saw the deceased alive on 23 September 1968 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.								
22b. SIGNATURE Peter J. Rosen, MD		22c. DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22d. DATE SIGNED 9/24/68			
22d. PHYSICIAN'S NAME (Type) Peter J. Rosen, MD.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-26-68	23c. NAME OF CEMETERY OR CREMATORIAL Oakwood Mem. Park		23d. LOCATION (City or Town) High Point, No. Car.	(County)	(State)	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland	25a. REC'D BY REGISTRAR SEP 27 1968		25b. REG STAR'S SIGNATURE Charles Judge			

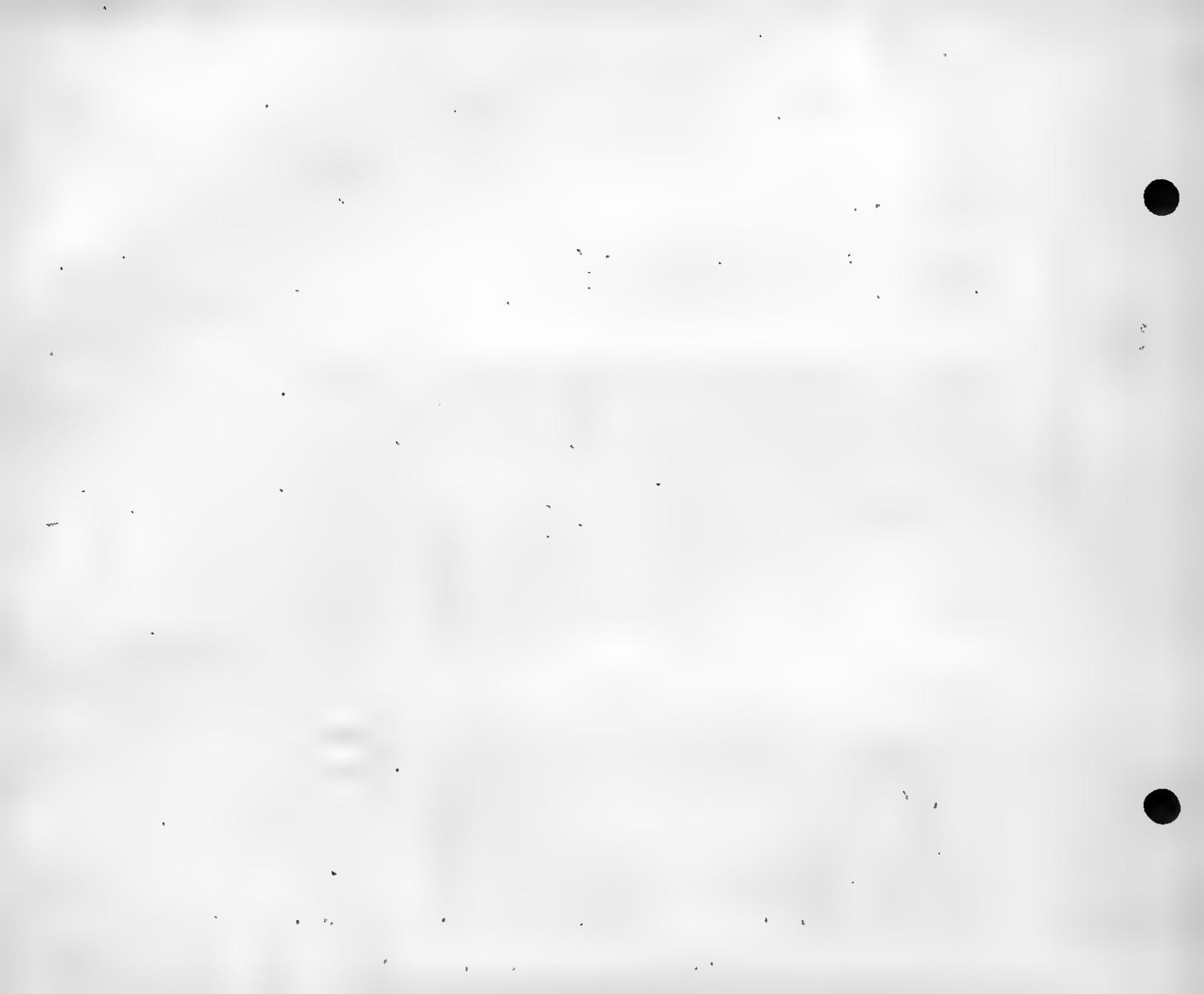


CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Arthur</i>	Middle <i>Vernon</i>	Last <i>Jarrett</i>	2a. DATE OF DEATH Month <i>Sept</i>	Doy <i>26</i>	Year <i>1968</i>	2b. HOUR <i>1:15 PM</i>				
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>April 28, 1906</i>		6. AGE (In years last birthday) <i>62</i>	YRS	1f. UNDER 1 YEAR MONTHS <i>0</i>	1f. UNDER 24 HRS DAYS <i>0</i>	1g. IF UNDER 24 HRS HOURS <i>0</i>	1h. MIN <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>Alabama</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery</i>	Md							
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. San. & Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Sell & employed</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Gen. Supply</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>PRO GEORGES</i>	13c. CITY OR TOWN <i>Lanham</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>7292 Finns Lane</i>							
14. FATHER'S NAME First <i>Arthur L.</i>	Middle <i>Jarrett</i>	15. MOTHER'S MAIDEN NAME First <i>Alma</i>	Middle <i>Garnett</i>		Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>420 10 1418</i>	17. INFORMANT <i>Patients chart</i>	Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>cardiac arrest</i>					6 m.						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>4109</i>					3.6 m.						
(b) <i>myocardial infarction</i>					3.6 m.						
DUE TO, OR AS A CONSEQUENCE OF (c) <i>extremely coronary disease</i>					2 months						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <i>1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>7</i> Month <i>July</i> Day <i>26</i> Year <i>1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) <i>1968</i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>1968</i>		21f. LOCATION Street or R.F.D. No. <i>1968</i>	City or Town <i>Hyattsville, Md.</i>		County <i>Md.</i>		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>7/1/68</i> to <i>7/26/68</i> , that (I) (we) last saw the deceased alive on <i>7/1/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED <i>7/26/68</i>	
22b. SIGNATURE <i>Hugh Trey MD</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (Type) <i>Hugh Trey MD</i>		22e. ADDRESS <i>1968 - N.H.A.C. 3rd Fl.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9/28/68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Ft Lincoln Cemetery</i>		23d. LOCATION (City or Town) <i>Colmar Manor</i>		(County) <i>Pro Geo</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D. BY REGISTRAR DATE <i>SEP 30 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



13166

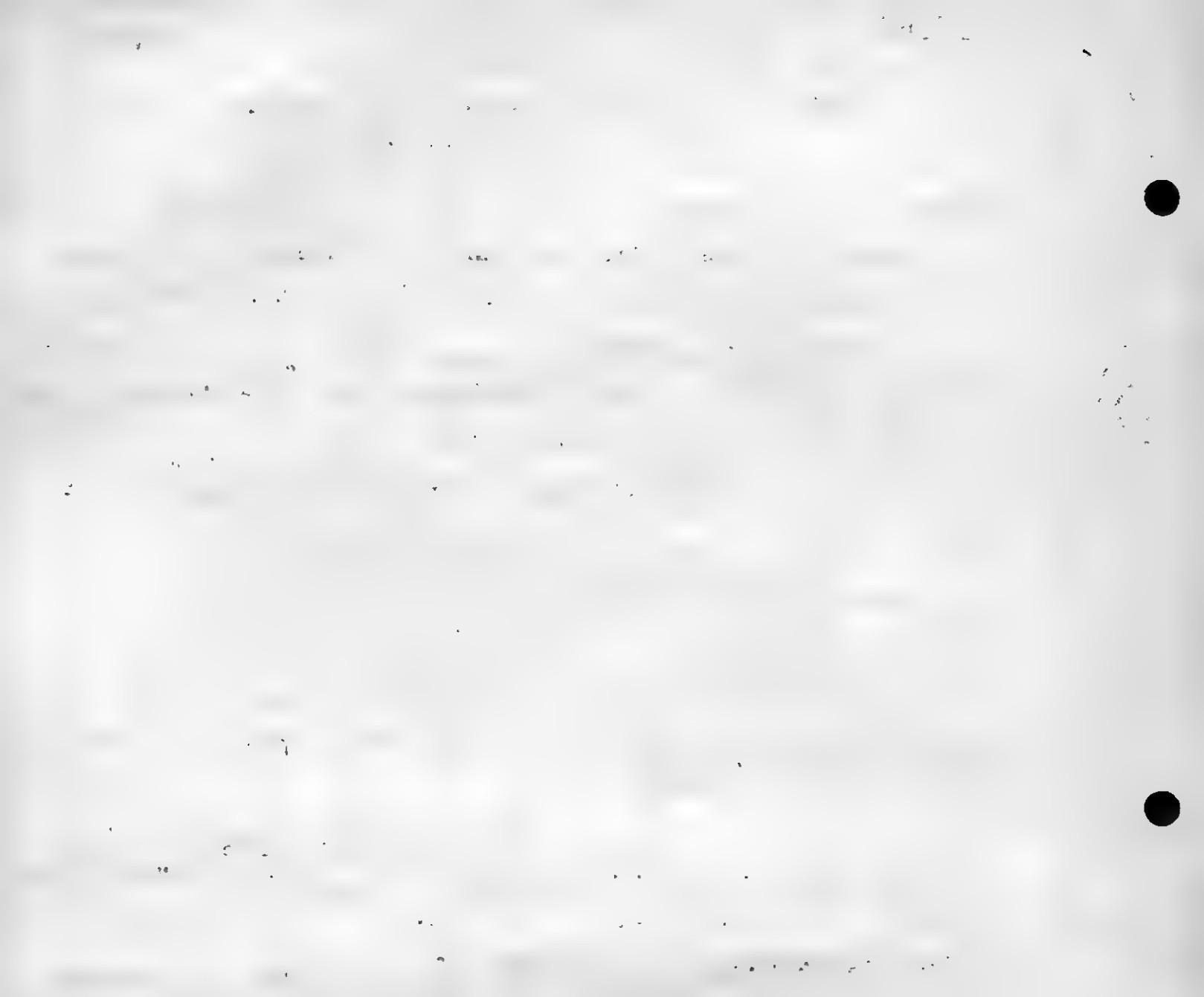
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13178

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First David	Middle Harry	Last Jenter	2a. DATE OF DEATH Month September	Day 7	Year 1968	2b. HOUR P 9:45 M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 2 March 1941			6. AGE (in years last birthday) 27	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Canada	7b. CITIZEN OF WHAT COUNTRY? Canada	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teacher			12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Canada	13c. CITY OR TOWN Fonthill	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER P.O. Box 787					
14. FATHER'S NAME First Harry	Middle M.	Last Jenter	15. MOTHER'S MAIDEN NAME First Margaret			Middle Chappell	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO. None	17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause liver (b) Metastatic Choriocarcinoma involving lungs and liver DUE TO, OR AS A CONSEQUENCE OF (c)						9 Months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Edema								
19a. DATE OF OPERATION 16-5 X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that Arthur L. Levy attended the deceased from 14 August, 1968 , to 7 Sept., 1968 , that we last saw the deceased alive on 7 September 1968 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, we (did) not view the body after death.								
22b. SIGNATURE Arthur L. Levy	DEGREE M.D.	ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 8 September 1968			
22d. PHYSICIAN'S NAME (Type) Arthur L. Levy, M.D.	22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept 11/68	23c. NAME OF CEMETERY OR CREMATORIUM Fonthill Ont Canada			23d. LOCATION (City or Town) Fonthill	(County) Ontario	(State) Can.	
24. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda MD	ADDRESS Robert A. Pumphrey Bethesda MD	25a. REC'D BY REGISTRAR SEP 13 1968			25b. REGISTRAR'S SIGNATURE Charles J. Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13167

CERTIFICATE OF DEATH

13179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Hallie</i>	Middle <i>Lee</i>	Last <i>Jewell</i>	2a. DATE OF DEATH Month <i>Sept</i>	Day <i>28</i>	Year <i>1968</i>	2b. HOUR <i>12:30 PM</i>			
3 SEX <i>Female</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>3/15/19</i>	6 AGE (in years last birthday) <i>49</i>	F UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	HOURS <i>00</i>	MIN. <i>00</i>			
7a BIRTHPLACE (State or foreign country) <i>W. Va.</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>							
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b KIND OF BUSINESS OR INDUSTRY <i>Montgomery</i>							
13a USUAL RESIDENCE (Where deceased admission) STATE <i>Md.</i>	13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Boyle's</i>	13d INSIDE C.TY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <i>Blk 11 Box 15-6B</i>						
14. FATHER'S NAME First <i>Charles</i>	Middle <i>Stevens</i>	15. MOTHER'S MAIDEN NAME First <i>Lucy Jennings</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>214-46-6141</i>	17 INFORMANT <i>Ethel Tolson</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hepatic Failure</i> Conditions, if any which gave rise to immediate cause (a) stating the underlying cause <i>Carcinomatosis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>174 X</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1911 X</i>										
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State								
22a I certify that (I) (this hospital) attended the deceased from <i>Feb - 1968</i> , to <i>Sept 28, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 27 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED <i>Robert A. Barnett</i>				
22d. PHYSICIAN'S NAME (Type) <i>ROBERT A. BARNETT</i>	22e. ADDRESS <i>809 Viennalee Rd., Barnesville, Md.</i>	ATTENDING PHYS. <input type="checkbox"/> MID- DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10/1/68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Boyle's Presbyterian</i>	23d. LOCATION (City or Town) <i>Boyle's</i>	(County) <i>Montgomery</i>	(State) <i>Md.</i>					
24. FUNERAL DIRECTOR <i>W.C. Hilton Barnesville, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13168

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13180

1. DECEASED NAME (Type or print)	First <i>Erick LEANDER</i>	Middle <i>Johnson</i>	Last <i>Jones</i>	2a. DATE OF DEATH Month <i>Sept</i>	Day <i>2</i>	Year <i>1968</i>	2b. HOUR <i>1 PM</i>
3. SEX <i>male</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>11/18/99</i>	6. AGE (in years less birthday) <i>68</i>	7. IF UNDER 1 YEAR MONTHS <i>0</i>		8. IF UNDER 24 HRS. HOURS <i>0</i>	
7a. BIRTHPLACE (State or Foreign country) <i>Sweden</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Maryland</i>		Md		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>				
13a. US-JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Maryland</i>	13c. CITY OR TOWN <i>Cherry Chase</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>3718 Williams Lane</i>			
14. FATHER'S NAME First <i>Unknown</i>	Middle <i>Unknown</i>	Last <i>Unknown</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Unknown</i>	Last <i>Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>470-01-4425</i>	17. INFORMANT <i>Friend John D. Leonard</i>	Address <i>Same as above</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>CVA</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <i>lost</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <i>331X</i>							
19a. DATE OF OPERATION <i>3/3/68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i>None</i>	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <i>None</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.) <i>None</i>	21f. LOCATION Street or R.F.D. No. <i>None</i>	City or Town <i>None</i>	County <i>None</i>	State <i>None</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>8/25/68</i> , 19 <i>68</i> , to <i>9/2/68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7/2/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death <i>None</i>							
22b. SIGNATURE <i>Paul D. Cantor</i>	DEGREE <i>None</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9/2/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>Paul D. Cantor, M.D.</i>	22e. ADDRESS <i>4709 Montgomery Ln Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9/5/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Gettysburg Natl. Cem. 7557 Wisconsin Ave ROBERT A. PUMPHREY, Bethesda, Maryland</i>	23d. LOCATION (City or Town) <i>Gettysburg, Adams, Penna.</i>	(County) <i>Adams</i>	(State) <i>Penna.</i>		
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	ADDRESS <i>7557 Wisconsin Ave</i>	25a. REC'D BY REGISTRAR <i>SEP 10 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

4.36

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

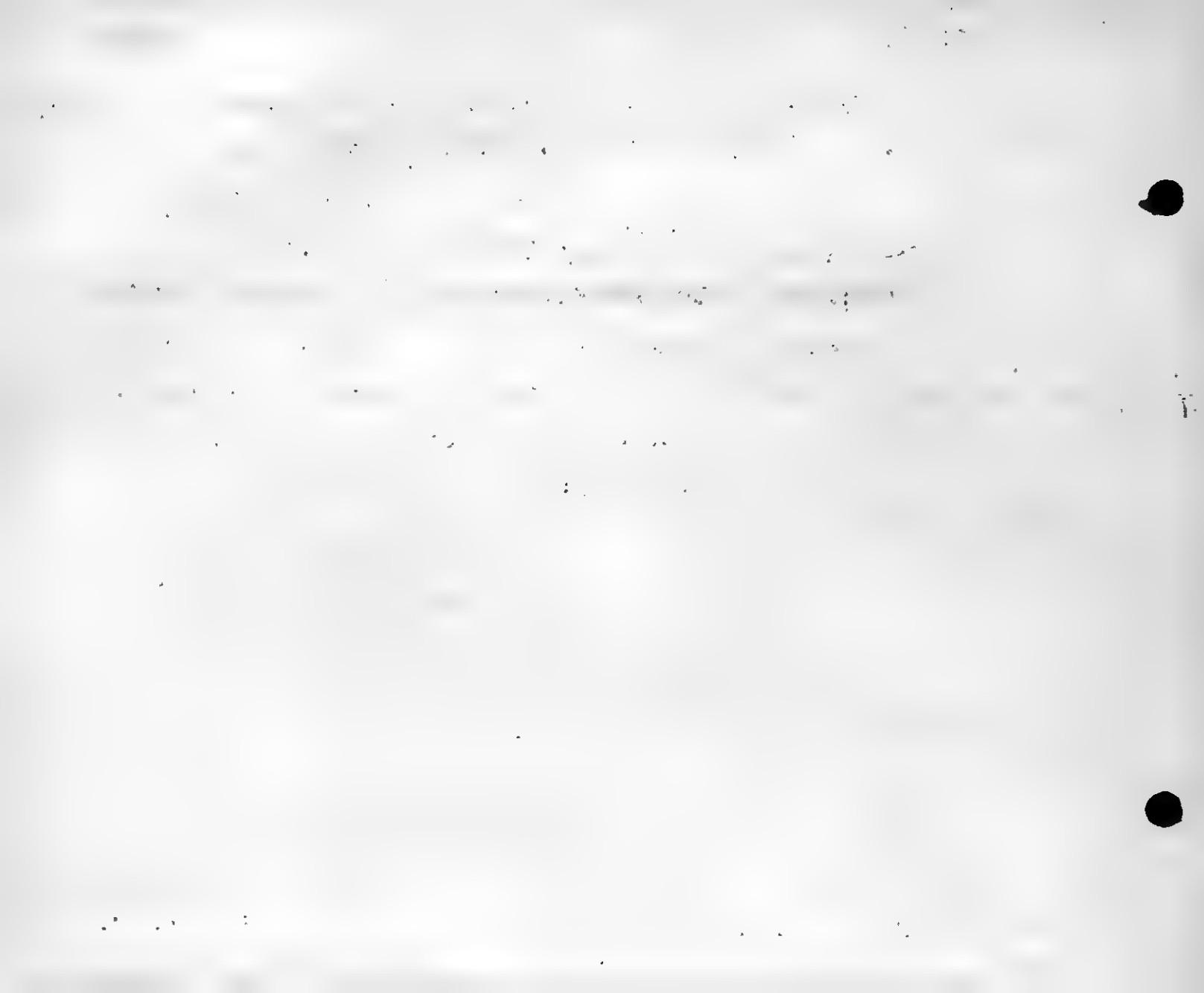
CERTIFICATE OF DEATH

13181

1 DECEASED NAME (Type or print)	First . NETTIE	Middle Lee	Last JOHNSON	2a. DATE OF DEATH Month SEPTEMBER	Day 14	Year '68	2b. HOUR 6:25	
3. SEX FEMALE	4. RACE CAUCASIAN	S. DATE OF BIRTH APRIL 9, 1886	6 AGE (In years last birthday) 82	7. IF UNDER 1 YEAR MONTHS 82	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN 0	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY DAMASCUS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 26142 RIDGE RD.					
14. FATHER'S NAME First Thomas	Middle Hungerford	15. MOTHER'S MAIDEN NAME First Middle Sallie	Peddicord					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Walter S. Johnson, Damascus, Md.	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure, 4154 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arterosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 - 2 weeks				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 Malnutrition, cause undetermined, probably from anorexia								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State			
22a. I certify that (I) (This hospital) attended the deceased from Sept. 7, 1968 , to Sept. 14, 1968 , that (I) (we) last saw the deceased alive on Sept. 14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Gene U. Cohen M.D.	DEGREE ATTENDING PHYS.	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Sept. 14, 1968				
22d. PHYSICIAN'S NAME (Type) GENE U. COHEN M.D.	22e. ADDRESS 1106 SPRING ST. SILVER SPRING MD 20910							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 17, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Providence	23d. LOCATION (City or Town) (County) (State) Glenelg, Md.					
24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.	25a. REC'D BY REGISTRAR DATE SEP 18 1968	25b. REGISTRAR'S SIGNATURE Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13182

1. DECEASED NAME (Type or Print)	First <i>Herbert</i>	Middle <i>Waldmere</i>	Last <i>Josephson</i>	2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/>	Month <i>Sept</i>	Day <i>12</i>	Year <i>1968</i>	2b HOUR <i>5:30 P.M.</i>			
3. SEX <i>m.</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>10/7/03</i>	6. AGE (in years last birthday) <i>64 yrs.</i>	7. IF UNDER 1 YEAR MONTHS <i>0</i>	8. IF UNDER 24 HRS DAYS <i>0</i>	9. HOURS <i>0</i>	10. MIN. <i>0</i>	10c DATE PRONOUNCED DEAD Month <i>Sept</i>	11d DAY <i>12</i>	11e YEAR <i>1968</i>	12b HOUR <i>6:00 A.M.</i>
7a BIRTHPLACE (State or foreign country) <i>New York</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>							
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Vice-President</i>	12b KIND OF BUSINESS OR INDUSTRY <i>Jones A. Company</i>								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Totomac</i>	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>11905 Evid Dr.</i>							
4. FATHER'S NAME First <i>Alfred</i>	Middle <i>Josephson</i>	Last <i>Josephson</i>	15. MOTHER'S MAIDEN NAME First <i>Alice</i>	Middle <i>Josephson-(Wife)</i>	Last <i>add. same.</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no) <input type="checkbox"/> No	16b SOCIAL SECURITY NO (If yes give war or dates of serv etc.)	17. INFORMANT <i>Alice Josephson-(Wife) add. same.</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction -</i> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>coronary occlusion.</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Recent</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>H.L.C.</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John S. Bell</i>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>Rockville, Montgomery Co. Md.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-16-1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) <i>Rockville, Montgomery Co. Md.</i>		(County)		(State)	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. 11.W., Wash., D.C., 20016</i>		ADDRESS <i>5130 Wisc. Ave.</i>		25a. REG'D BY REGISTRAR DATE <i>SEP 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

100-100-100

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First DORA	Middle R.	Last KANSTOROOM	2a. DATE OF DEATH Month SEPTEMBER	Day 8	Year 1968	2b. HOUR 7:30 P.M.
3. SEX FEMALE	4 RACE white	5. DATE OF BIRTH 8/26/03		6. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0
7a. BIRTHPLACE (State or foreign country) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK		12b. KIND OF BUSINESS OR INDUSTRY US GOV'T.		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRG.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 12135 DAVID DRIVE			
14. FATHER'S NAME First LOUIS	Middle ROBIN	Last	15. MOTHER'S MAIDEN NAME First BESSIE	Middle ALPERT	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 578-22-1066	17. INFORMANT SON DR. ALLEN R. KANSTORM	Address S. S. 140 DR.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Weeks		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary Abscess & Broncho Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 1739 (b) Improper Esophageal Motility DUE TO, OR AS A CONSEQUENCE OF (c) Met. Carcinoma from Skin More than							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1419 20yrs.							
19a. DATE OF OPERATION 14/19		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (his hospital) attended the deceased from 9/16/1968 to 9/18/1968 , that (I) (we) last saw the deceased alive on 9/18/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Lennard		MD DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9/18/1968		
22d. PHYSICIAN'S NAME (Type)	G. LENNARD GOLD MD		22e. ADDRESS 9801 - GEORGIA AVE SILVER SPRING MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-11-68	23c. NAME OF CEMETERY OR CREMATORIAL KING DAVID MEMORIAL GARDEN FALLS CHURCH VA	23d. LOCATION (City or Town) FALLS CHURCH VA	(County)	(State)		
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS	ADDRESS WASH. D.C.	25a. REC'D BY REGISTRAR DA SEP 16 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SEARCHED

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 13 Film G45

13172

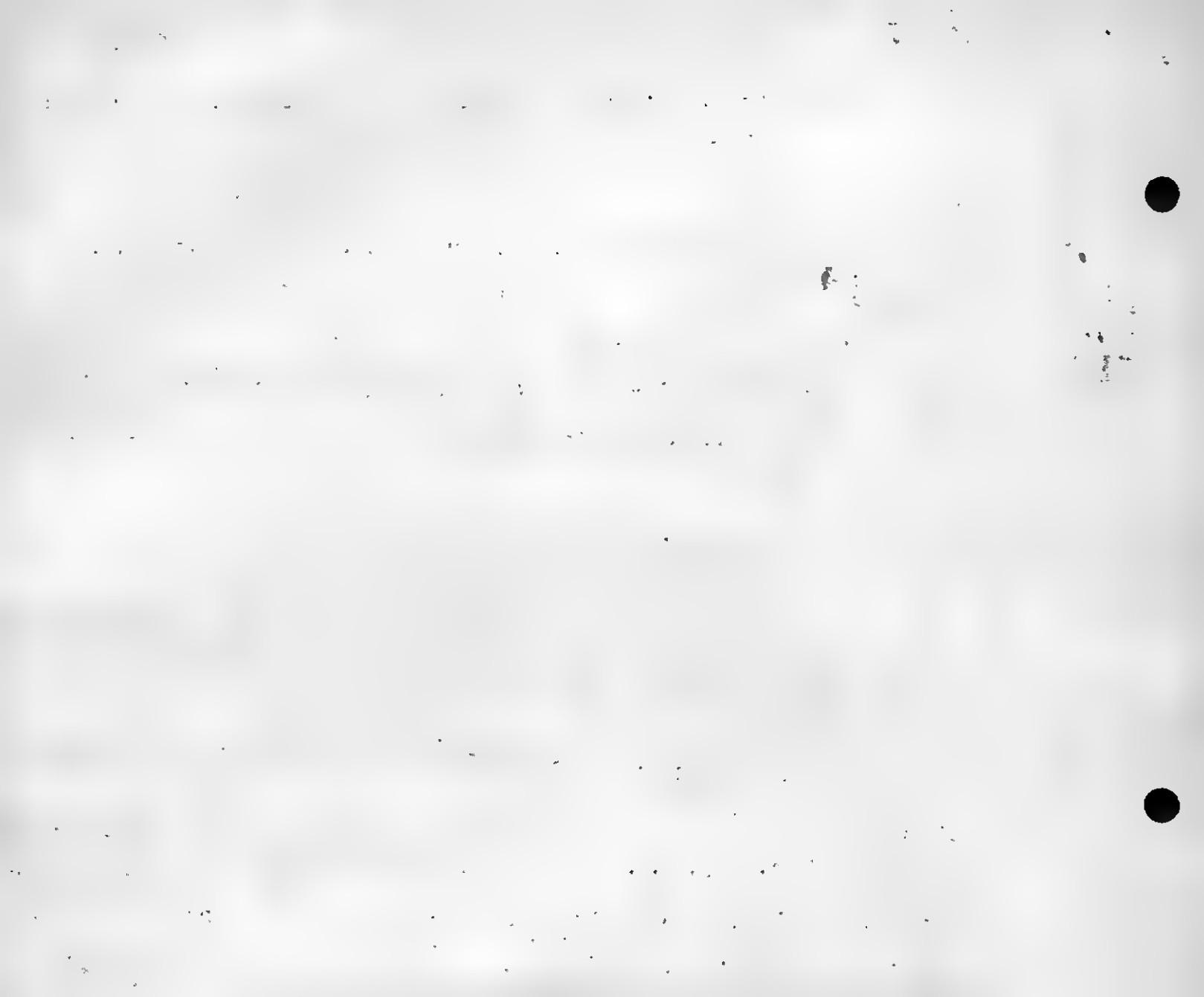
CERTIFICATE OF DEATH

13185

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper (4 pages) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Gabriel	Middle Louis	Last Kaplan	2a. DATE OF DEATH Month September	Day 17	Year 1968	2b. HOUR 11:19 A.M.
3. SEX Male	4 RACE White	5. DATE OF BIRTH 14 September 1901			6. AGE (in years lost birthday) 67 yrs	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Public Administration		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Virginia	13b. COUNTY Arlington	13c. CITY OR TOWN Arlington	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES	13e. STREET AND NUMBER 2001 North Adam Street	Md.		
14. FATHER'S NAME First Harry	Middle Kaplan	Last	15. MOTHER'S MAIDEN NAME First Yetta	Middle	Last Gottlieb		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. 1942-1946	17. INFORMANT The Medical Record, Clinical Center, NIH, Bethesda, Maryland 20014	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Hypernephroma 189.0 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 189.0							
19a. DATE OF OPERATION MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6 August</u> , 1968, to <u>17 Sept.</u> , 1968, that <input type="checkbox"/> (we) last saw the deceased alive on <u>17 Sept.</u> , 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE David A. Bray, M.D.	22c. DATE SIGNED 17 September 1968						
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/18/68	23c. NAME OF CEMETERY OR CREMATORIUM King Solomon Cemetery	23d. LOCATION (City or Town) Clifton, Passaic Co. N.J.	(County)	(State)		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.	7557 ADDRESS ROBERT A. PUMPHREY, Bethesda, Md.	25a. REC'D BY REGISTRAR DATE SEP 23 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

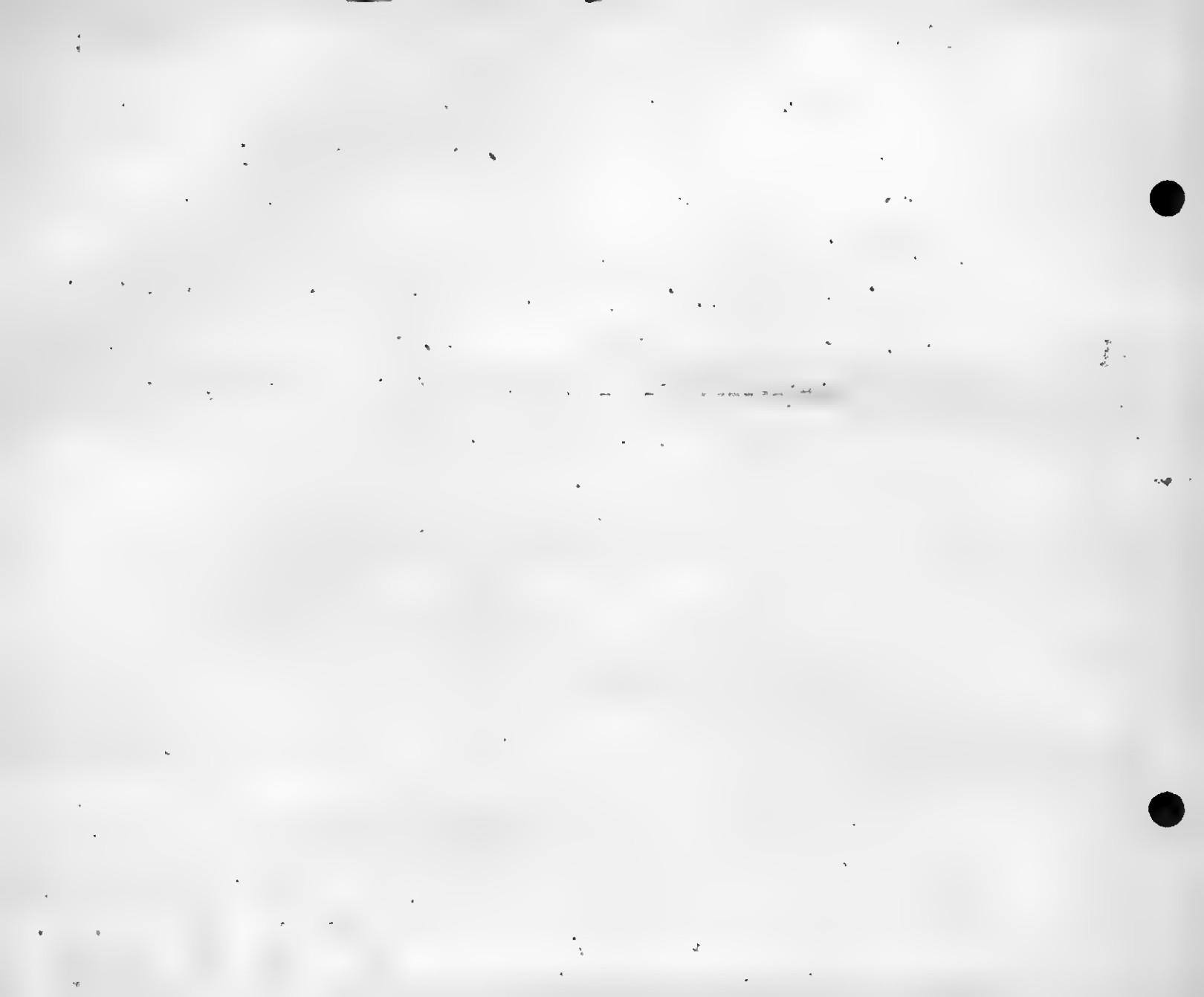
13173

13186

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2, and 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>Della</i>	Middle <i>V.</i>	Last <i>Kefauver</i>	2a DATE OF DEATH Month <i>Sept -</i>	2b HOUR Year <i>1968</i>
3. SEX <i>F</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>May 3, 1896</i>	6 AGE (in years last birthday) <i>72 yrs.</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Penn s.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b KIND OF BUSINESS OR INDUSTRY <i>5400 Poole's Hill Rd.</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIM. T57 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>5400 Poole's Hill Rd.</i>	
14. FATHER'S NAME First <i>Edward</i>	Middle <i>F</i>	Last <i>Miller</i>	15. MOTHER'S MAIDEN NAME First <i>Louise.</i>	Middle <i>Johns.</i>	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <i>No</i>	16b. SOCIAL SECURITY NO. <i>none</i>	16c. INFORMANT <i>Husband Clarence Kefauver</i>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia</i> 41-7 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>Atherosclerotic Heart Disease</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on <i>9/21/68</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Wm L. Howell MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <i>Wm L. Howell</i>		22e. ADDRESS <i>Washington Clinic N.H. DC 20005</i>	22f. DATE SIGNED <i>9/22/68</i>		
23a. BURIAL, CREMATION, REMOVAL (For 5) <i>Burial</i>	23b. DATE <i>9/25/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>	23d. LOCATION (City or Town) <i>Prince Georges Co. Md.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>The S.I. Lines Co.</i>	24b. ADDRESS <i>1267-14th St. N.W.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE <i>SEP 24 1968</i>	



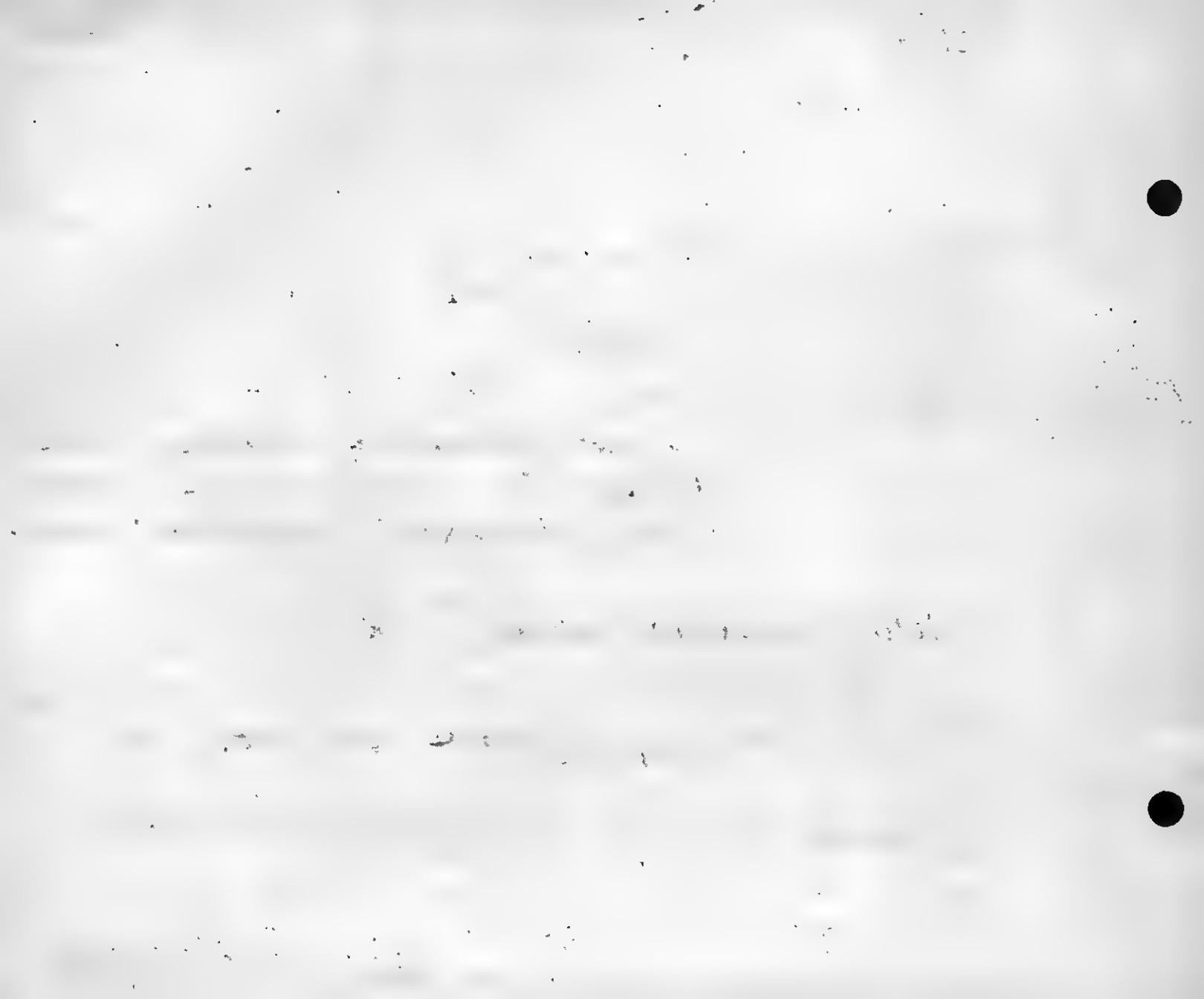
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13184

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove top 2 pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)	First IRENE	Middle —	Last KELLMAN	2a. DATE OF DEATH Month Sept.	Day 13	Year 1968	2b. HOUR 10:10 P.M.
3. SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH 1-21-1902		6. AGE (In years last birthday) 66 yrs	7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Russia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH MONTGOMERY				
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. & HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE	12b. KIND OF BUSINESS OR INDUSTRY —			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE NEW YORK	13b. COUNTY ✓	13c. CITY OR TOWN LONG BEACH	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 450 SHORE RD.			
14. FATHER'S NAME First ABRAHAM	Middle COOPERSTEIN	Karen Kellman	15. MOTHER'S MAIDEN NAME First TILLIE	Middle —	Last MAGAZANICK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) Unknown	17. INFORMANT Alvin Kellman (son)	Address Spacious Mill 48 Circle Dr. WSN				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 5/4/1		Acute pulmonary embolism				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		Postoperative Cholecystectomy				7 days	
(b) DUE TO, OR AS A CONSEQUENCE OF		Chronic cholecystitis & cholelithiasis				2 mos.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 9/6/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystectomy & cholelithiasis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Sept. 13, 1968 , to Sept. 13, 1968 , that (I) (we) last saw the deceased alive on Sept. 13, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Frederick B. Brandt		DEGREE ATTENDING PHYS. MD.	DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9/14/68		
22d. PHYSICIAN'S NAME (Type) FREDERICK B. BRANDT		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 15, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Montefiore Cemetery		23d. LOCATION (City or Town) Queens, New York	(County) —	(State) —
24. FUNERAL DIRECTOR Memorial Funeral Home		ADDRESS Donald M. Stein Hebrew 232 Carroll St., N.W. Wash.	25a. REC'D BY REGISTRAR DATE Sep 16 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.



Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13175

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13187

1. DECEASED NAME (Type or Print)			First John	Middle Dwight	Last Kendall Sr.	2a DATE KNOWN OF EST DEATH MATED <input checked="" type="checkbox"/>	Month 9	Day 7	Year 1968	2b HOUR 9:51 AM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH 10-10-1887	6 AGE (in years at birthday) 80	IF UNDER MONTHS YRS	YEAR DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 9 Day 7 Year 1968				2d HOUR 9:51 AM
7a BIRTHPLACE (State or foreign country) Washington, DC		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OR DEATH Montgomery						
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital or nursing home address) Potomac Valley Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Attorney				12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Wash D.C. 13b COUNTY		13c CITY OR TOWN Wash. D.C.		13d INSIDE CITY, IN TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 3000 39th St. NW						
14. FATHER'S NAME First John			Middle Blake	Last Kendall	15. MOTHER'S MAIDEN NAME First Mary				Middle D.	Last Hooker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO (If yes give name or dates of service) W.W.I		17 INFORMANT Jr. John D. Kendall, Son,				ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Carcinoma of Lung,</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Cleft main-stem bronchus,</i> (b) <i>With metastasis</i> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621											
19a. DATE OF OPERATION 1621			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden R. Leep</i>		CHIEF MEDICAL EXAMINER M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED SEPT. 8, 1968			
EXAMINER'S NAME (Type) BELDEN R. LEAP, M.D., Voluntarily		ADDRESS Cedar Hill Crematory		23d LOCATION (City or Town) Suitland, Prince Georges Co.		(County) Md.		(State) Md.			
23a BURIAL, CREMATION, REMOVAL. (Specify) Cremation		23b DATE 9-9-1968		23c NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d LOCATION (City or Town) Suitland, Prince Georges Co.		(County) Md.			
24. FUNERAL DIRECTOR Joseph Gowler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS 5130 Wisc. Ave.		25a. REGISTRATION NUMBER SEP 11 1968		25b. REGISTRATION STAMP Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13176

CERTIFICATE OF DEATH

13188

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place it in my carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First NORMAN	Middle P	Last KENDIG	2a. DATE OF DEATH Monthly Sept 26 1968	Day 26	Year 1968	2b. HOUR 4 PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH 4/12/08		6 AGE (In years last birthday) 60	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) WASH, DC.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
8 WIDOWED <input type="checkbox"/>	9 DIVORCED <input type="checkbox"/>	10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital	12a. USWA. OCCUPATION (Kind of work done during most of working life, even if retired) Cable Splicer	12b. KIND OF BUSINESS OR INDUSTRY Impel Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES	13e. ZIP CODE AND NUMBER 20901 100TH ST AVE	13f. STREET AND NUMBER 7001 HENRY DR.		
14 FATHER'S NAME First SAM	Middle KENDIG	Last EDNA	15. MOTHER'S M AIDEN NAME First MARJORIE L.	Middle FUSS	Last SAME AS (13e)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO 577-01-1240	17 INFORMANT MARJORIE L. KENDIG SAME AS (13e)	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colitis leading to pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Colitis leading to pneumonia (b) Concurrent of lung with infection DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE, BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from June 1968 to Sept 1968 that (I) (we) last saw the deceased alive on 25 Sept 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul T. Noone MD	22c. DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 26 Aug 68		
22d. PHYSICIAN'S NAME (Type) PAUL T. NOONE	22e. ADDRESS SILVER SPRING MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-28-68	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) Silver Spring	(County) Montgomery	(State) MD.		
24. FUNERAL DIRECTOR Mr. Chambers	ADDRESS Silver Spring Md	25d. RECEIVED BY REGISTRAR DATE SEP 27 1968	25e. SIGNATURE Paul T. Noone				



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

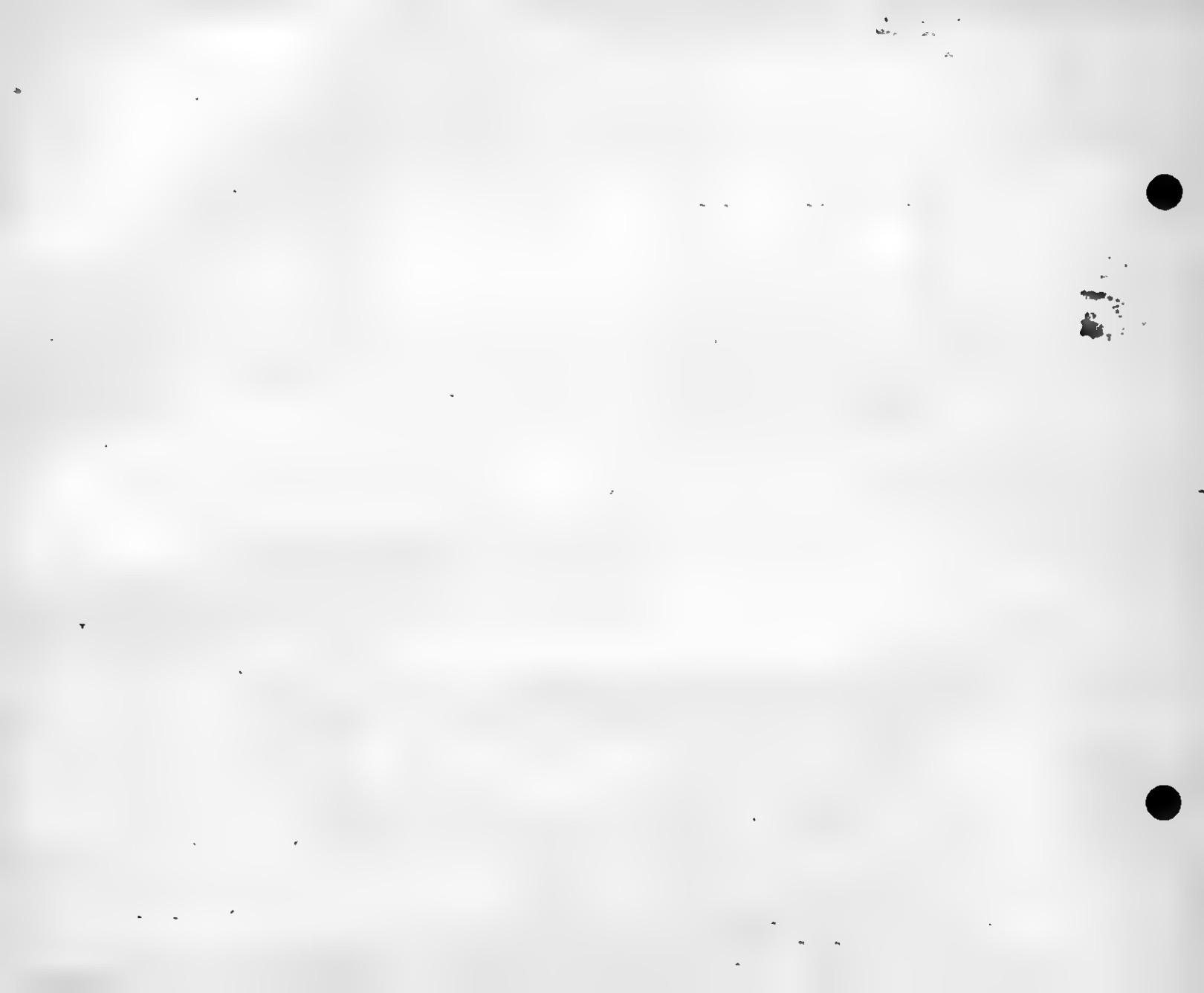
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13189

13177

1 DECEASED NAME (Type or Print)	First <i>DAVID</i>	Middle <i>Stewart</i>	Last <i>KERN</i>	2a DATE KNOWN OF ESTI- DEATH MATED	Month <i>Sept</i>	Day <i>22</i>	Year <i>1968</i>	2b HOUR A.M.				
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>May 2 1968</i>	6 AGE (in years at birthday) <i>4 yrs</i>	F UNDER 1 YEAR MONTHS <i>4</i>	IF UNDER 24 HRS DAYS <i>0</i>	HOURS <i>0</i>	MIN. <i>0</i>	2c DATE PRONOUNCED DEAD Month <i>Sept</i>	Day <i>22</i>	Year <i>1968</i>	2d HOUR A.M.	
7a BIRTHPLACE (State or foreign country) <i>Bethesda, Md.</i>	7b c) IN WHAT COUNTRY? <i>U.S.A.</i>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>							
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>None</i>			12b KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Wheaton</i>	13d. INSIDE CITY LIMIT? <i>YES</i>	13e. STREET AND NUMBER <i>11604 Viers Mill Rd</i>								
14. FATHER'S NAME <i>David</i>	First <i>S.</i>	Middle <i>Kern</i>	Last	15. MOTHER'S MAIDEN NAME <i>Cezanne Marie Carley</i>	First <i>David S. Kern</i>	Middle <i>Wheaton, Maryland</i>	Last <i>11604 Viers Mill Road</i>	ADDRESS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>None</i>	17. INFORMANT <i>David S. Kern</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> DUE TO, OR AS A CONSEQUENCE OF <i>411x</i> Conditions, if any, which gave rise to immediate cause (a) } stating the underlying cause } last. (b) <i>Aspiration of gastric contents</i> DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4216</i>												
19a. DATE OF OPERATION <i>4/21/68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>Sept 22 1968</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <i>Vomited and aspirated gastric contents</i>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>	21f. LOCATION Street or R.F.D. No <i>11604 Viers Mill Rd.</i>	City or Town <i>Wheaton</i>	County <i>Montgomery</i>	State <i>Md.</i>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John G. Ball</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Sept 23, 1968</i>					
EXAMINER'S NAME (Type)	M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Sept 24, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek Cemetery</i>			23d. LOCATION (City or Town) <i>Washington, D.C.</i>	(County)	(State)					
24. FUNERAL DIRECTOR <i>C. G. Carter 8434 Georgia Avenue</i>	25a. REC'D BY REGISTRAR <i>Warren E. Pumphrey, Inc. Silver Spring, Maryland</i>			25b. REGISTRAR'S SIGNATURE <i>Charles J. George</i>								
DATE SEP 27 1968												



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13178

13190

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Bertha	Middle Marie	Last King	2a. DATE OF DEATH Month Sept. 23, 1968	Year 1968	2b. HOUR A 2:40 M
3 SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 22, 1901		6. AGE (in years last birthday) 67 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Clarksburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt#1, Box 165		
14. FATHER'S NAME Maurice	First E.	Middle Beall	15. MOTHER'S MAIDEN NAME Mary	Jane	Purdum	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give year or dates of service)	17. INFORMANT Leslie C. King, Clarksburg, Md.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
(b) <u>Arteriosclerotic Cardiovascular Disease with Hypertension</u>				15 years		
(c) <u>Heart Block</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Severe Diabetes Mellitus						
19a. MEDICAL CERTIFICATE ON DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b) No Injury				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from January, 1935, to Sept. 23, 1968, that (I) (we) last saw the deceased alive on September 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Kendree Boyer, M.D.</i>	DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED September 23, 1968	
22d. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.	22e. ADDRESS 9701 Church Street Damascus, Maryland,					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 25, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Upper Seneca Baptist	23d. LOCATION (City or Town) Cedar Grove, Md.	(County)	(State)	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.	ADDRESS	25a. REC'D BY REGISTRAR Date SEP 25 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13179

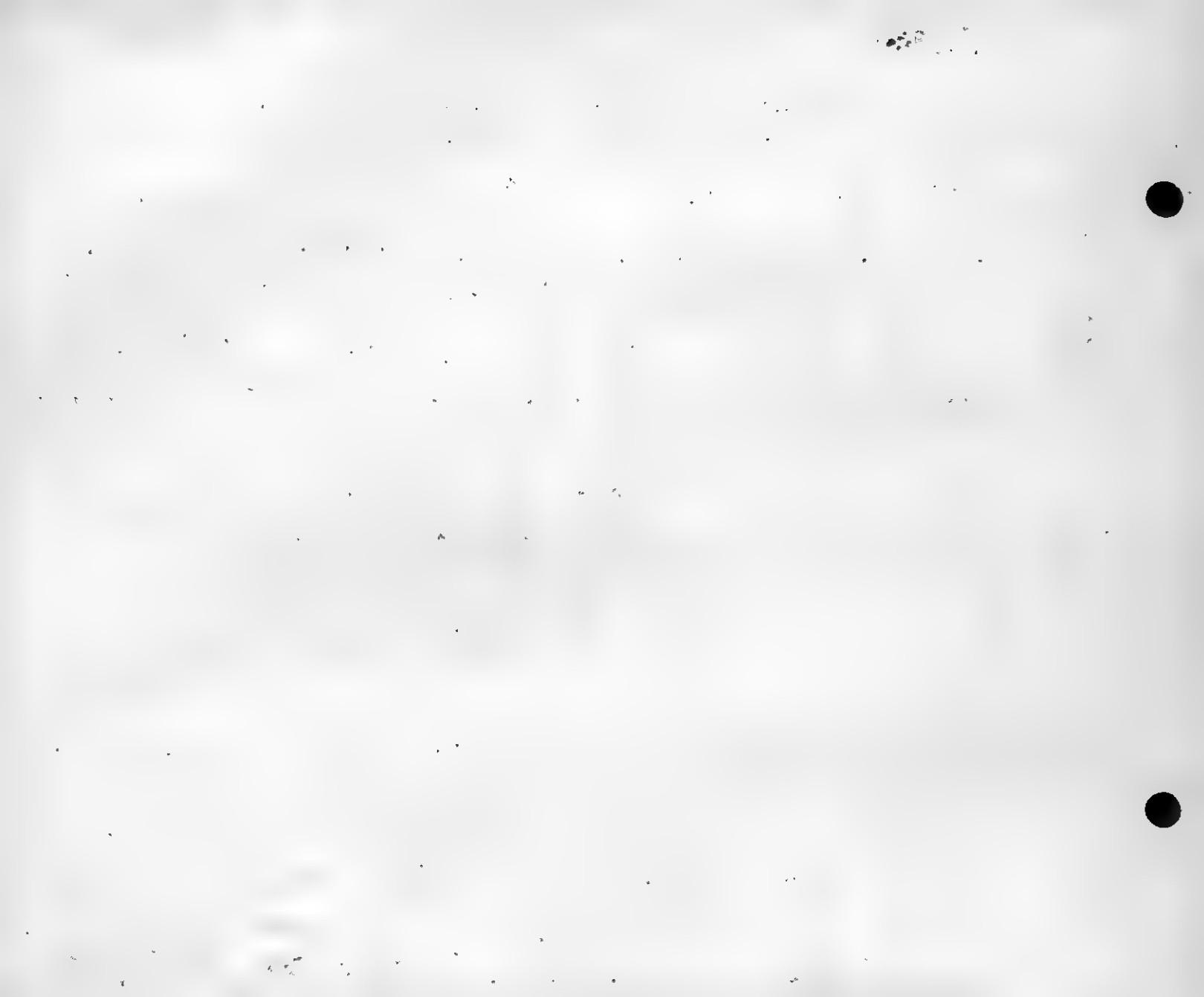
13191

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and every event, within 24 hours after death.

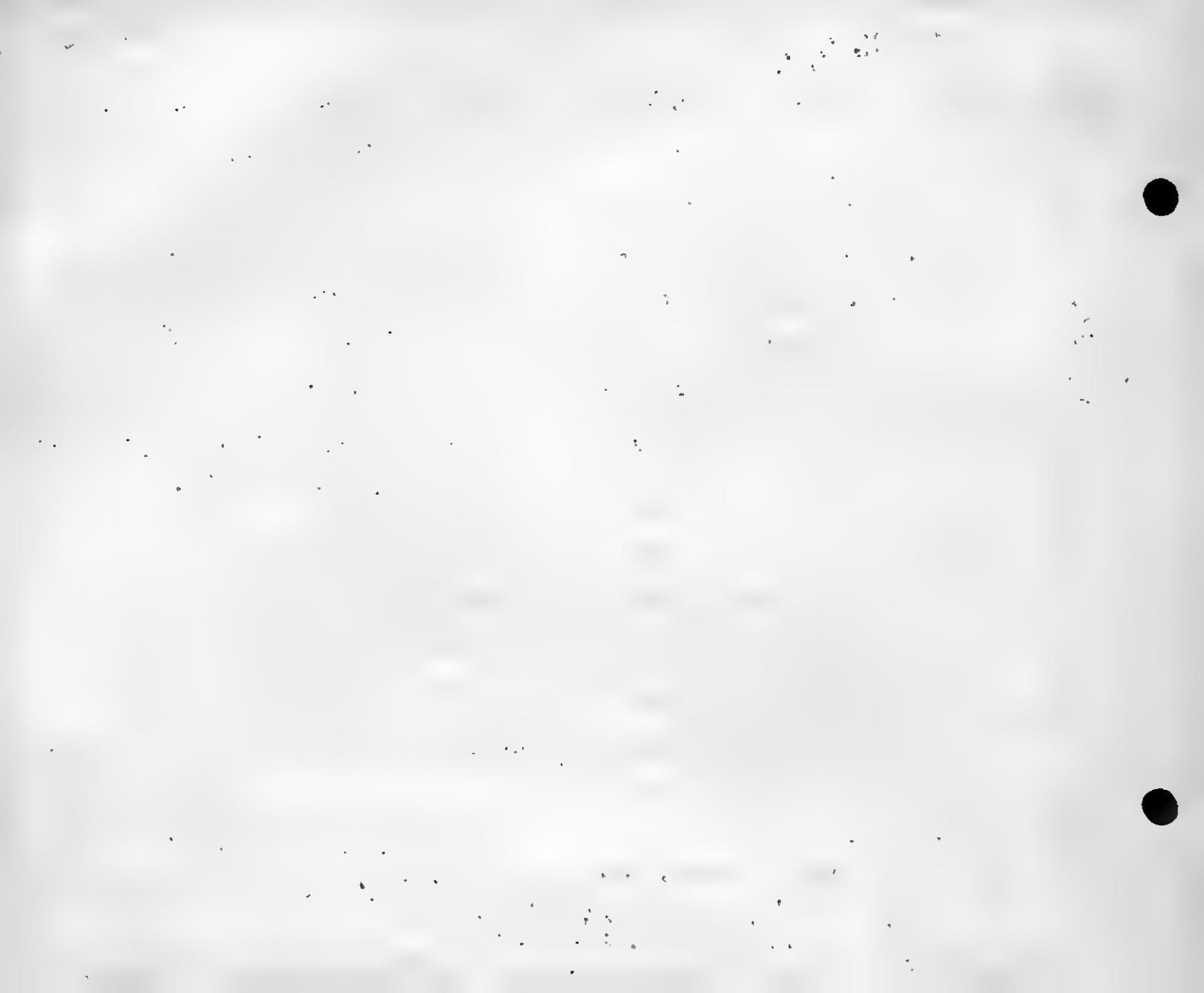
1. DECEASED NAME (Type or print)	First <i>FRANCES</i>	Middle <i>Marie</i>	Last <i>King</i>	2a. DATE OF DEATH Month <i>Sept</i>	Day <i>20</i>	Year <i>68</i>	2b. HOUR 6pm	
3. SEX <i>FEMALE</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>2/18/23</i>	6. AGE (In years lost birthday) 45 yrs	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (State or foreign country) <i>Penns USA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery County Md</i>					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b. KIND OF BUSINESS OR IND.STRY <i>own home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>1703 - FRANWALL Avenue</i>				
14. FATHER'S NAME First <i>Samuel</i>	Middle <i>Dobra</i>	15. MOTHER'S MAIDEN NAME First <i>Welisava</i>	Middle <i>XXXXXX</i>	Last <i>Yustic</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>186-14-0371</i>	17. INFORMANT <i>Edward G. King</i>	Address <i>1703 Franwall Ave. S.S., Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Hepatic Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>1558</i> (b) <i>Hepatic Metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Adenocarcinoma of Colon</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>153</i>						<i>few mos.</i>		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (This hospital) attended the deceased from <i>March, 1968</i> , to <i>1/20, 1968</i> , that (I) (we) last saw the deceased alive on <i>9/20 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>G. Leonard Gold</i>	DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9/21/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>G. Leonard Gold M.D.</i>	22e. ADDRESS <i>9801 Georgia Avenue Silver Spring, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Sept. 24, '68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Sepulchre</i>	23d. LOCATION (City or Town) <i>Philadelphia</i>	(County) <i>Montgomery Pa.</i>	(State)			
24. FUNERAL DIRECTOR M. Andrew Duvall Warner E. Pumphrey Inc., 8434 Ga. Ave. S.S., Md.	ADDRESS <i>M. Andrew Duvall</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
DATE <i>SEP 25 1968</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove double papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												13192	
1 DECEASED NAME (Type or print)			First <i>Fred</i>	Middle <i>Mason</i>	Last <i>King</i>	2a. DATE OF DEATH			2b. HOUR				
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (in years last birthday)			Month <i>September</i>	Day <i>27</i>	Year <i>1968</i>	2 15 p.m.
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			7b. CITIZEN OF WHAT COUNTRY? <i>American</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>				
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington San + Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired - government</i>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE <i>Maryland</i>			13c. CITY OR TOWN <i>Montgomery Silver Spring</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <i>10012 Kinross Avenue</i>				
14. FATHER'S NAME First <i>Samuel</i>			Middle <i>King</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Sarah</i>			Middle	Last <i>Gleason</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Unknown</i>			16b. SOCIAL SECURITY NO. <i>220-44-6831</i>			17. INFORMANT <i>Hospital Records</i>			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4109</i> Acute myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>36 hours</i>													
DUE TO, OR AS A CONSEQUENCE OF: (b) Arteriosclerotic cardiovascular disease													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>74</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 27, 1968</i> , to <i>Sept 27, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 27, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Raymond Bradshaw, M.D.</i>		22c. DEGREE ATTENDING PHYS			MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			DATE SIGNED <i>Sept 27, 1968</i>					
22d. PHYSICAL NAME (Type) <i>Raymond Bradshaw, M.D.</i>		22e. ADDRESS <i>345 University Blvdt, W. Silver Spring, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Sept 30, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>St. John's Church Cemetery</i>			23d. LOCATION (City or Town) (County) <i>Forest Glen, Silver Spring, Md.</i>		(State)				
24. FUNERAL DIRECTOR <i>J. Walter Walters</i>		25a. ADDRESS <i>254 Carroll St. NW Washington, D.C. 20012</i>		25b. REC'D BY REGISTRAR <i>OCT 1 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

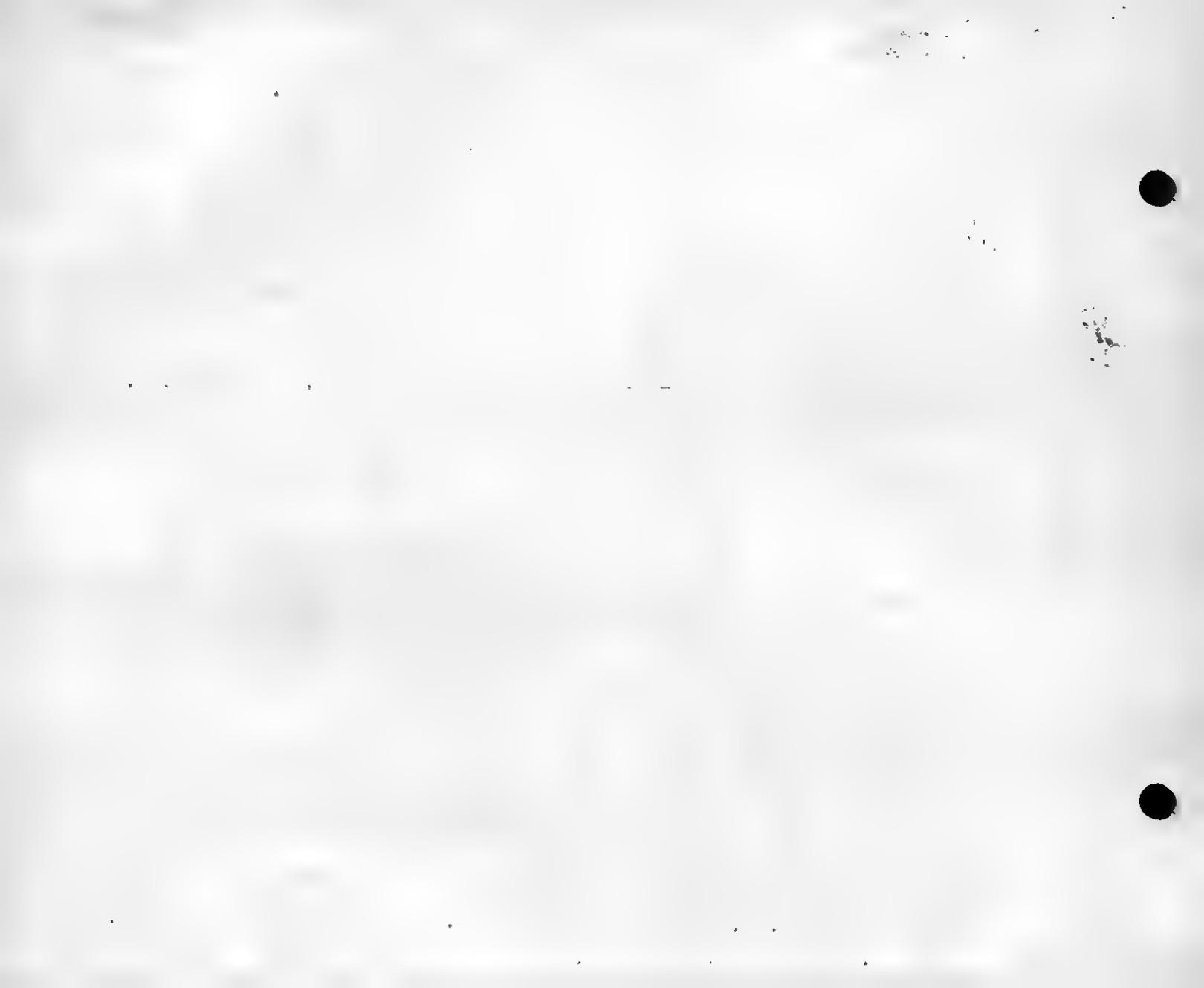
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1318 13193 CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First Ora	Middle Henning	Last King	20. DATE OF DEATH Sept. Month 26 Doy 68 Year	2b. HOUR 5am M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 7-18-10		6. AGE (in years at birthday) 58	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	Md.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Post Master		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13c. CITY OR TOWN Clarksburg	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 114			
14. FATHER'S NAME First Elias King	Middle	Last	15. MOTHER'S MAIDEN NAME First Jemina Purdum	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO 213-12-4127	17. INFORMANT Hospital Records.	Address Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 301 X						
19a. DATE OF OPERATION 301 X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 9-24, 1968 , to 9-26, 1968 , that (I) (we) last saw the deceased alive on 9-25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Frederick Moormann, M.D.		ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED 9-26-68	
22d. PHYSICIAN'S NAME (Type) FREDERICK MOORMANN, M.D. - SANDY SPRING MEDICAL CENTER, SANDY SPRING, MD.		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 28, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Clarksburg Meth.	23d. LOCATION (City or Town) Clarksburg, Md.	(County)	(State)
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		ADDRESS	25a. REC'D BY REGISTRAR SEP 30 1968	25b. REG STRR'S SIGNATURE Charles Judge	DATE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13182

CERTIFICATE OF DEATH

13194

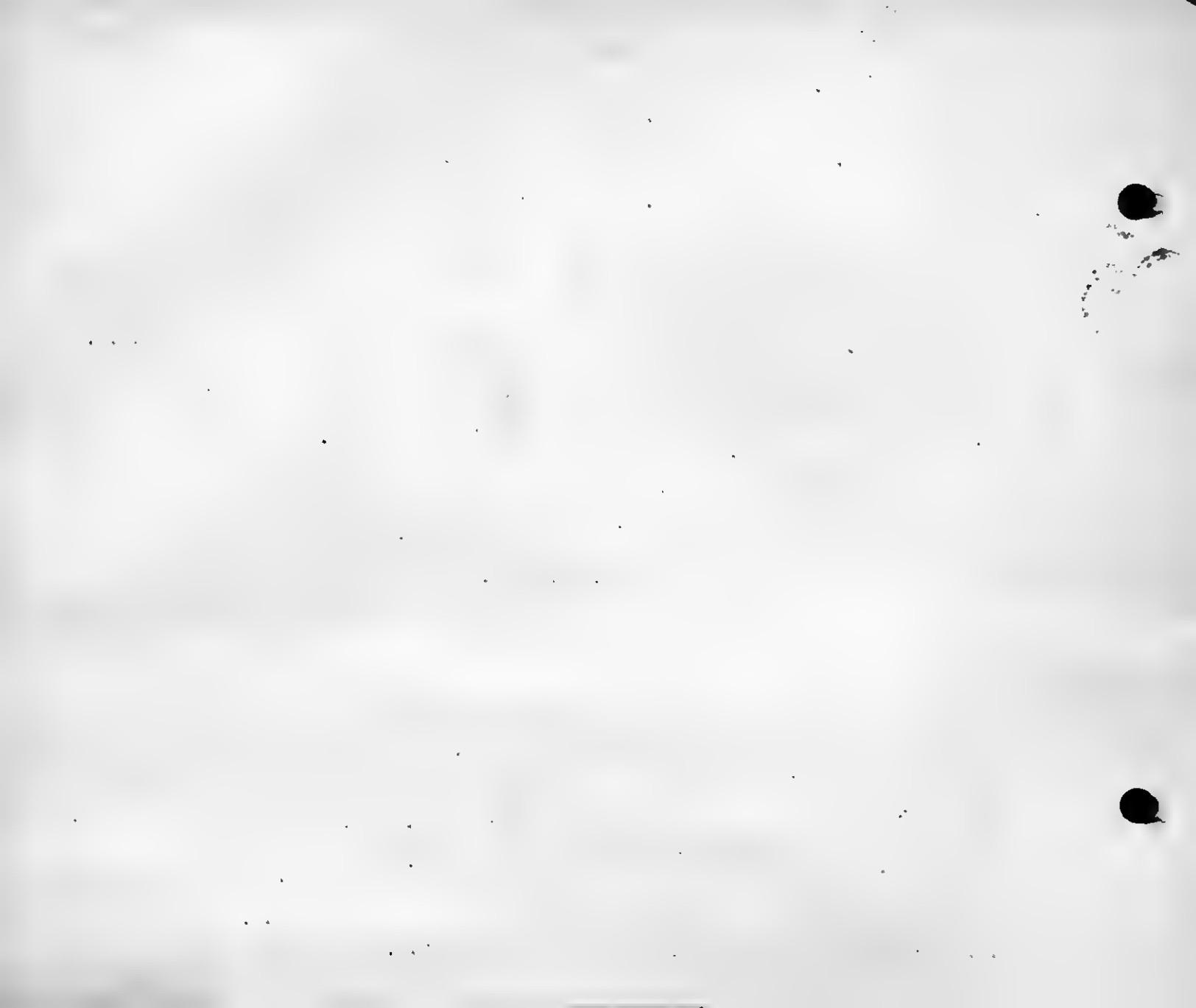
Reg. Dist. No.

TO HOSPITAL OR HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 1/58

1. PLACE OF DEATH o COUNTY Montg. Md		2. USUAL RESIDENCE (Where deceased lived / If institution Residence before admission) o. STATE D.C. ✓ COUNTY	
Washington Sanitarium & Hospital. MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park Md. Wash	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Takoma Park Md.		d. STREET ADDRESS 713 Varnum St. NW	
c. LENGTH OF STAY IN lb		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital.		4. DATE OF DEATH Month 9/6 Day 16 Year 1968	
3. NAME OF DECEASED (Type or print) William King		First	Middle
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-02
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - artist		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Wash D.C.	
13. FATHER'S NAME Benjamin F. King		14. MOTHER'S MAIDEN NAME Mary Alice Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown)		INFORMANT Mrs Mildred Ellis. Address	
No		16. SOCIAL SECURITY NO	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
COPONARY Occlusion. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		COPONARY Heart Disease. Generalized Arteriosclerosis -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on		Jan 1950 to Oct 6 1968, that I last saw the deceased	
and that death occurred at 115th and 15th Sts., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Washington D.C. DATE SIGNED 9-6-68	
ACTUAL SIGNATURE Francis J. Sharpe M.D. 4105 Wisconsin Ave			
PHYSICIAN'S NAME (Type) Francis J. Sharpe		Wash D.C. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/68	
22c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery		22d. LOCATION (City, town, or county) Wash D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.H. Huntemann & Son Inc.		ADDRESS 5732 Georgia Av. REC'D BY REGISTRAR	
		DATE SEP 10 1968	
		24b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13183

CERTIFICATE OF DEATH

13195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Frances	Middle A.	Last Kirkland	2a. DATE OF DEATH Month Sept.	Year 5 1968	2b. HOUR P.M. 12:50 M
3. SEX F	4 RACE Caucasian	S. DATE OF BIRTH 4-28-85	6 AGE (In years last birthday) 83 YRS.	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) ILL.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Lintherton	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Hills Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nursing	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montgomery Silver Spring	13c. CITY OR TOWN Montgomery Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8720 Cameron St.		
14. FATHER'S NAME James	Middle Jones	Last Hannah	15. MOTHER'S MAIDEN NAME McCarthy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?	16b. SOCIAL SECURITY NO 3446-05-1054	17. INFORMANT John I Kirkland	Address 6012 Beech Ave	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos.		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4 ne phrosclerosis & atherosclerosis						
19a. DATE OF OPERATION ✓		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this-hospital) attended the deceased from 10-5-1968, to 9-5-1968, that (I) (we) last saw the deceased alive on 9-3-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Kunsel B. Arnold M.D.		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9-5-68	
22d. PHYSICIAN'S NAME (Type) R. SSEK B. Arnold M.D.		22e. ADDRESS 1106 Spring Street Silver Spring, Md. 20910				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-9-68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Holy Sepulchre.	23d. LOCATION (City or Town) Worth.	(County) III	(State)	
24. FUNERAL DIRECTOR Robert A. Pompey 7557 Wisconsin Ave	25a. REC'D BY REGISTRAR DATE SEP 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

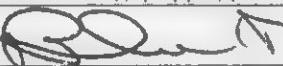
13196

13184

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR Hour Min.	
Thomas Simes Kitsoulis				9 16 68	8:45 AM	
3. SEX Male	4 RACE White	5. DATE OF BIRTH 1/16/04	6. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Greece	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH Silver Spring	Md. 130 County		
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>					
10. CITY OR TOWN OF DEATH Wheaton Md	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Hospital RETIRED			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MARYLAND	13c. CITY OR TOWN Montgomery	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 10820 Georgia Ave.			
14. FATHER'S NAME First SIMOS -	Middle	Last	15. MOTHER'S MAIDEN NAME First MARIA. KOUTSIS	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No	16b. SOC. A. SECURITY NO. 578-46-9174	17. INFORMANT	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 342X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Parkinsonism DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF Approximate interval between onset and death 3 days 5 years						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of left hip.						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH If either, notify medical examiner		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While Not while at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from June 1968, to Sept 16, 1978, that (I) (we) last saw the deceased alive on Sept 14 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED Sept 16, 1968		
22d. PHYSICIAN'S NAME (Type) BLAINE H. E. L.	22e. ADDRESS 9501 Georgia Ave. Silver Spring, Md.					
23a. BURIAL/CREMATION REMOVAL (Specify) REMOVAL	23b. DATE 18 Sept 1968	23c. NAME OF CEMETERY OR CREMATORIAL Glenwood	23d. LOCATION (City or Town) Washington D.C.	(County)	(State)	
24. FUNERAL DIRECTOR Rinaldi Funeral Home	25a. REC'D BY REGISTRAR DATE SEP 20 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

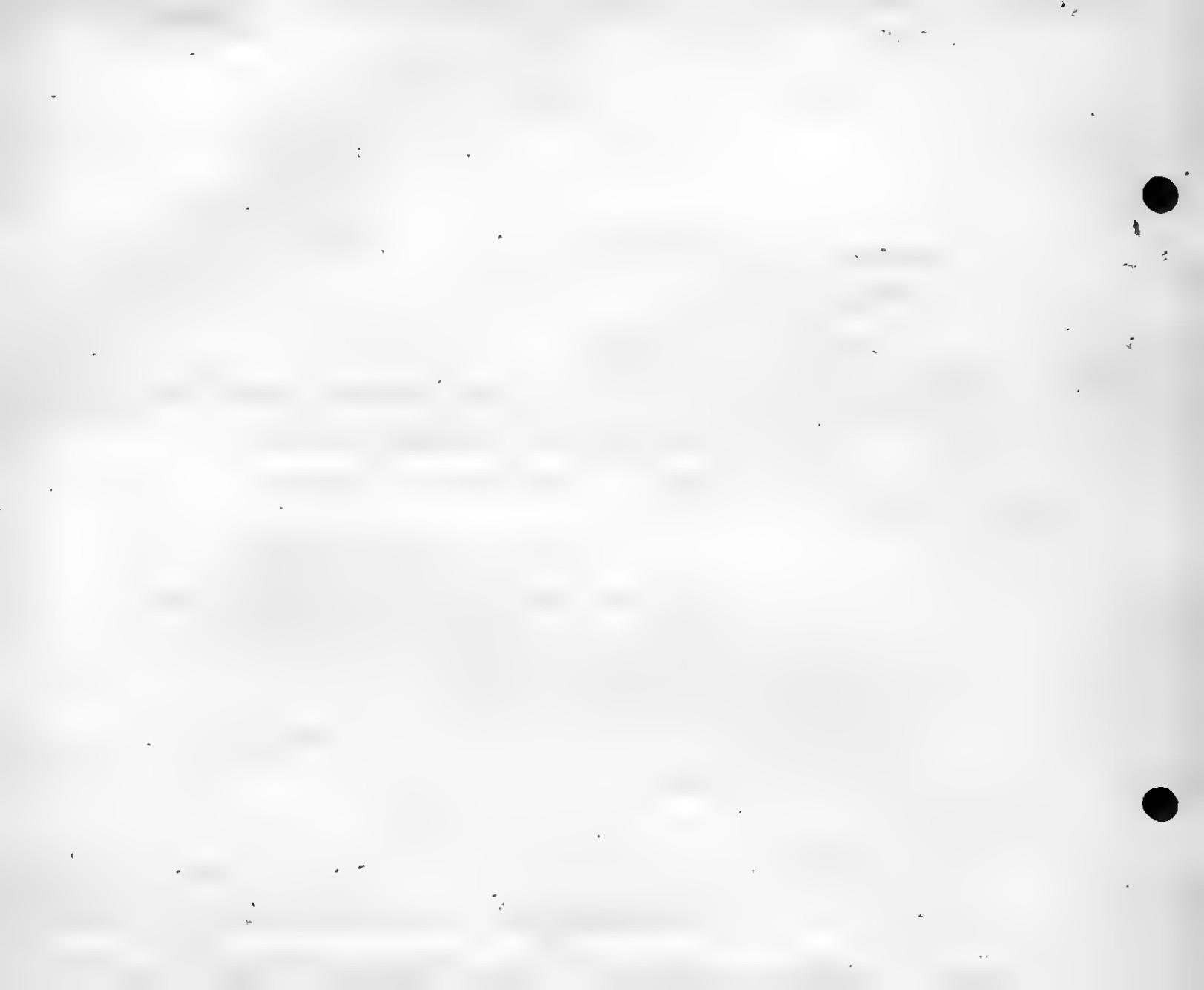
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If you do not have a director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 128197

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First Bernard	Middle Klateman	Lost	2a. DATE OF DEATH Month Sept	Day 25	Year 1968	2b. HOUR 09	M	
3. SEX Male	4. RACE White	S. DATE OF BIRTH Sept 24 1911	6. AGE (In years last birthday) 57	7. IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pa	7b. CITIZEN OF WHAT COUNTRY? U.S	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH Bethesda Chevy Chase	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital g ve street address) 4701 Willard Ave	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant					12b. KIND OF BUSINESS OR IND. STRY Florist		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 4701 Willard Avenue					
14. FATHER'S NAME First David	Middle Klateman	15. MOTHER'S MAIDEN NAME First Middle Mary							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17. INFORMANT Mrs. Shirley Klateman - above	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC OBSTRUCTIVE EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.E.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 24 1968 , to PRESENT , 19_____, that (I) (we) last saw the deceased alive on Sept 24 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE P. Gregg Rhodes MD		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9/25/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS George Washington University Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-27-68	23c. NAME OF CEMETERY OR CREMATORIUM KING DAVID MEMORIAL GARDEN FALLS CHURCH VA.		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR B. DANZANSKY & SONS - WASHINGTON DC	ADDRESS	25a. REC'D BY REGISTRAR SEP 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13186

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH 13198

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Doy	Year	2b. HOUR 12 ⁴ M
Charles Louis Klingelhofer						9	15	1968	
3. SEX		4 RACE	S. DATE OF BIRTH			6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian	9/24/69			98		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
BALTO. MD.		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Potomac Valley Nursing Home			DENTIST			DENTAL PROF.	
13a. U.S. AL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.		Mont.		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7009 Glenbrook Rd.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
John Ernest Klingelhofer					Mary Altvater				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				H.E.Klingelhofer		7009 Glenbrook Rd., Bethesda			
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART I DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Alfred S. Norton M.D.</u>									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22c. DATE SIGNED 9/15/68					
Alfred S. Norton		7710 Dainger Dr. Bethesda Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)	(State)
CREMATION		9-6-68	GREENMOUNT			BALTO. MD.			
24. FUNERAL DIRECTOR		ADDRESS			25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
WM COOK-BROOKS, INC. 1217 ST. PAUL ST.					SEP 9 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												13199
Item#13c,b,e, Film#404 9/19/68 km CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR	130 M			
HENRY	T.	KREUTER		9	8	68						
3. SEX	4. RACE	S. DATE OF BIRTH										
MALE	CAUCASIAN	AUG 16, 1883										
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH									
WASH. D.C.	U.S.A.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	MONTGOMERY									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY							
SILVER SPRING	BELMONT NURSING			LABORER	U.S. GOVT							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residene before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	5200 Ryers							
MD.	P.G. MONTG.	SILVER SPR. Hotel.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	V172210/N/M/H/1A/VE								
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last					
			KREUTER	UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO	17. INFORMANT	Address									
NO	578-14-3391	NURSE - BELMONT NURSING HOME										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												
PART I. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) Myocardial Insufficiency TERMINAL												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a). Stating the underlying cause (b) Coronary Heart Disease CHRONIC												
DUE TO, OR AS A CONSEQUENCE OF												
(c) Atherosclerotic C.V.D CHRONIC												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
DIABETES MELLITUS												
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from Nov 1964 to 9/8 1968, that (I) (we) last saw the deceased alive on 9/3 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Ronald R. Lewis, MD												
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DEGREE		ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22f. DATE SIGNED 9/8/68			
DONALD R. LEWIS MD		700 CLOVERLY SILVER SPR. MD										
23a. BURIAL/CREMATION Cremation (Specify)		23b. DATE 9-19-68		23c. NAME OF CEMETERY OR Crematory		23d. LOCATION (City or town, County)		(State)				
				BELMONT CEMETERY		BELMONT		MD				
24. FUNERAL DIRECTOR		ADDRESS		25a. REG'D BY REGISTRAR SEP 11 1968		25b. REGISTRAR'S SIGNATURE						
Mr. Chambers Co		Riverside Md.				RONALD R. LEWIS						
VR A15 10 30M REV 10		DATE				DATE						

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13188

13200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Annie</i>	Middle <i>Agnes</i>	Last <i>Kunzecke</i>	20. DATE OF DEATH Month <i>SEPT</i>	Day <i>28</i>	Year <i>68</i>	2b HOUR <i>8:30 AM</i>
3 SEX <i>Female</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>1/14/1877</i>	6. AGE (in years lost birthday) <i>91 yrs</i>	J. UNDER 1 YEAR MONTHS <i>0</i>	DAYS <i>0</i>	HOURS <i>0</i>	IF UNDER 24 HRS MIN. <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>4571 MD.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>MONTGOMERY 4571 PRINCE GEORGE</i>				
10 CITY OR TOWN OF DEATH <i>Wheaton Md.</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wheaton Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Never worked</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>MD</i>	13c. CITY OR TOWN <i>Prince Georges Co Hyattsville</i>	13d. INSIDE CITY LIMIT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>8103 - 15th Hyattsville md</i>	Appt 102			
14. FATHER'S NAME First <i>Harry</i>	Middle <i>77-88</i>	Dingle lost	15. MOTHER'S MAIDEN NAME First <i>Mary F.</i>	Middle <i>Annie Agnes</i>	Last <i>Dingle</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>21-54-74867</i>	17. INFORMANT <i>for Mary Engling</i>	Address <i>Daugherty - 813-15th Ave Hyattsville MD 20783</i>				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	<i>congestive heart failure & shock</i>						<i>2 hrs</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4129</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic cardiovascular disease</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost.</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				<input type="checkbox"/> YES <input type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>28 Sept 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Walter E Goorh</i>							
22d. PHYSICIAN'S NAME (Type)	DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>9/28/68</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE <i>10-2-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood Cemetery</i>	23d. LOCATION (City or Town) <i>Baltimore, Maryland</i>	(County)	(State)		
24. FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Ave.</i>	ADDRESS <i>21229</i>	25a. REC'D BY REGISTRAR <i>OCT 3 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>Jacob</i>	Middle <i>Emanuel</i>	Last <i>Lacey</i>	2a DATE OF DEATH Month <i>9</i>	Doy <i>26</i>	Year <i>68</i>	26. HOUR <i>3:15</i>
3. SEX <i>Male</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>9-27-87</i>	6. AGE (In years last birthday) <i>80 yrs.</i>	IF UNDER YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (State or foreign country) <i>D.C.</i>	7b CITIZEN OF WHAT COUNTRY? <i>United States</i>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>	Md.			
10 CITY, OR TOWN OF DEATH <i>Takoma Park</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Sanitarium & Hospital</i>	12a USUAL OCCUPATION (Kind of work done during past of working life, even if retired) <i>Plasterer</i>	12b KIND OF BUSINESS OR INDUSTRY <i>Construction</i>				
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Washington D.C.</i>	13c CITY OR TOWN <i>Washington DC</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <i>27 Marlboro Place N.W.</i>				
14. FATHER'S NAME First <i>George E.</i>	Middle <i>Lacey</i>	15. MOTHER'S MAIDEN NAME First <i>Annie</i>	Middle <i>Ford</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>578-03-7809</i>	17 INFORMANT <i>Frank Lacey 205 Tanley Road Sil. Sot. Md.</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis, Acute</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) (b) <i>Coronary Heart Disease</i> 1 yr. stating the underlying cause lost. <i>421</i> (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1) <i>Pulmonary Emphysema</i> 2) <i>Bronchopneumonia w/ lung</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building etc.) <i>offce building etc</i>	21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Sep. 1967</i> , to <i>9-26-1968</i> , that (I) (we) last saw the deceased alive on <i>9-26-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Samuel A. Hillman</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>9-26-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>SAMUEL A. HILLMAN</i>	22e ADDRESS <i>8829 Flower Ave Silver Spring MD 20901</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9-30-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lincoln Cemetery</i>	23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR <i>Paul J. Smith</i>	ADDRESS <i>Warren E. Humphrey, Inc. 8434 Ga. Ave. S.S., Md.</i>	25a. RECD. BY REGISTRAR DATE <i>OCT 2 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13190

13202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 2 pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Bene	Middle Laffal	Last	2a. DATE OF DEATH Month 9 Day 26 Year 68	2b. HOUR 3 A.M.
3. SEX Male	4. RACE Kau	S. DATE OF BIRTH May 10, 1888	6. AGE (in years lost birthday) 80 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Russia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Garment Worker	12b. KIND OF BUSINESS OR INDUSTRY Clothing		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spr.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 929 Clintwood Drive	
14. FATHER'S NAME First Unknown	Middle	Last	15. MOTHER'S MAIDEN NAME First Unknown	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 083-09-0996	17. INFORMANT Martin Laffal 3109 Brooklawn Terr. Ch. Ch. Md	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cecre 1. Myocardial infarction</i> 4.00					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c)					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
4201		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 13</i> , 19 <i>68</i> , to <i>Sept. 13</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Sept. 13</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) (did not) view the body after death.					
22b. SIGNATURE <i>Morton Shapiro</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>10/1/68</i>	
22d. PHYSICIAN'S NAME (Type) Morton Shapiro, M.D.		22e. ADDRESS 8109 Eastern Ave., Sil. Spr., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-27-1968	23c. NAME OF CEMETERY OR CREMATORIAL National Memorial Park	23d. LOCATION (City or Town) Falls Church,	(County)	(State) Va.
24. FUNERAL DIRECTOR <i>Goldberg Funeral Home</i>	ADDRESS <i>4201 Gold St. Md.</i>	25a. REC'D BY REGISTRAR DATE <i>SEP 30 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13203

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN Month Day Year	2b HOUR 23 rd		
<i>George W.</i>				<i>LANGLEY</i>	<input checked="" type="checkbox"/> DEATH EST. <input type="checkbox"/> DEATH MATED	<i>Sept. 27 1968 12 PM</i>		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years at birthday)	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR 23 rd		
Male	W	3-15-93	75 YRS 6 12		<i>Sept. 27 1968 12 PM</i>			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
<i>Md.</i>		<i>USA</i>				<i>Montgomery</i>		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
<i>Bethesda</i>		<i>Suburban</i>				<i>MINER COAL</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
<i>MARYLAND</i>		<i>Montgomery</i>		<i>Rockville</i>		<i>14037 Travillah Road</i>		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last
<i>James</i>				<i>LANGLEY</i>	<i>KATHERINE</i>			<i>Pace</i>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT		ADDRESS		
<i>No</i>				<i>LEE FORD</i>		<i>son-in-law Same As Above</i>		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) <i>Lobar pneumonia, left lower lobe</i>		<i>3 days</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF						
(b) <i></i>		DUE TO, OR AS A CONSEQUENCE OF						
(c) <i></i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
<i>Malnutrition & emaciation severe -</i>								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20 AUTOPSY?				
				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1b)				
				<i>19</i>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		<i>John G. Ball</i>						
EXAMINER'S NAME (Type)		<i>John G. Ball</i>						
23a BURIAL, CREMAT. ON, REMOVAL (Specify)		23b DATE <i>9-29-68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Langley Family Cem.</i>		23d LOCATION (City or Town) <i>Hagan Lee Virginia</i>		
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG STRR DATE <i>OCT 1 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
<i>Tyson Wheeler Funeral Home 1331 Rockville Pk. Rockville, Maryland</i>								



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13204

13192

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)	First <i>CHARLES</i>	Middle <i>WILLIAM</i>	Last <i>LANHAM, Jr.</i>	2a. DATE OF DEATH Month <i>9 - 28 - 68</i>	Day <i>18</i>	Year <i>1968</i>	2b. HOUR 1 P.M.	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>12-18-25</i>		6. AGE (in years last birthday) <i>42 yrs.</i>		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i>		
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington & Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Ind. Freeway</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>MD.</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPRINGS</i>	13d. INS. DE. CITY LIM. TSP <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>13203 Collingwood Terrace</i>		
14. FATHER'S NAME <i>CHARLES</i>	First	Middle	Last	.5. MOTHER'S MAIDEN NAME <i>LANHAM SR</i>	15. MOTHER'S MAIDEN NAME <i>LOUISE S.</i>	First	Middle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes or No <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>579-20-9681</i>		17. INFORMANT <i>Betty M. Lanham</i>		Address <i>13203 Collingwood Terr., S.S. 20809</i>		
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>hereditary metastasis carcinoma severe</i> 3 months DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchogenic carcinoma</i> 3 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>16L</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/28/68</i> , 1968, to <i>9/28/68</i> , 1968, that (I) (we) last saw the deceased alive on <i>9/26/68</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Hugh W. Gray, M.D.</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>9/28/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Hugh W. Gray, M.D.</i>		22e. ADDRESS <i>11161 New Hampshire Ave. Sil. Spr., Md.</i>						
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-30-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) <i>Rockville</i>		(County) <i>Montgomery</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Clark E. Wisor Clark Funeral Sils. Spr. Md.</i>		ADDRESS <i>Warren E. Humphrey, Inc. 8434 Ga. Ave.</i>	25a. REC'D. BY REGISTRAR <i>OCT 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



13205

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

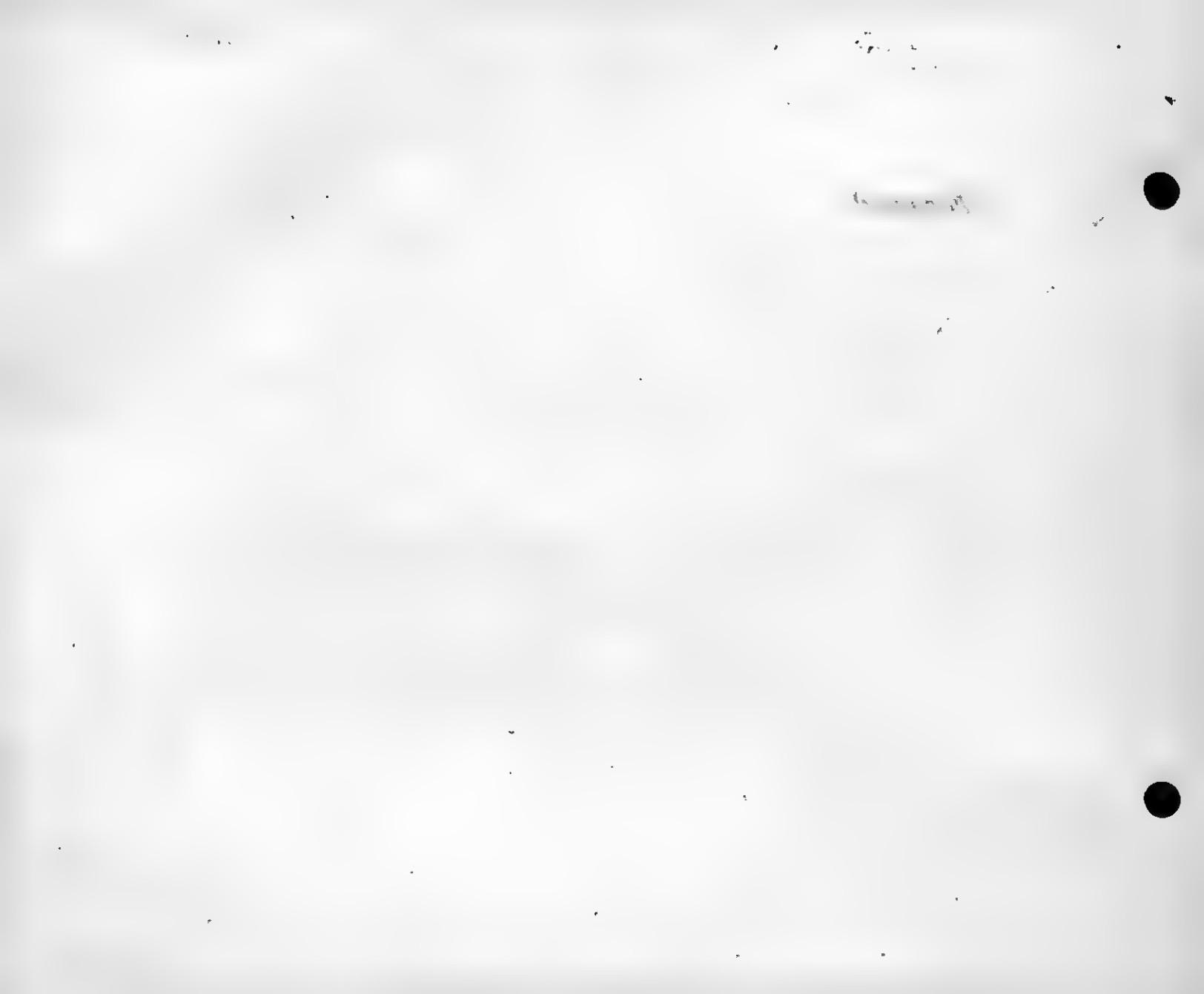
13195

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First <i>Ethe</i>	Middle <i>Viola</i>	Last <i>Lapham</i>	2a DATE KNOWN Month Day Year DEATH ESTI. DEATH MATED <i>Sept 6 1968</i>	2b HOUR 3:35 AM		
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>5/27/93</i>	6. AGE, in years last birthday <i>75 yrs.</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <i>0 0 0 0</i>	2c DATE PRONOUNCED DEAD Month Day Year <i>Sept 6 1968</i>	2d HOUR 3:35 AM	
7a BIRTHPLACE (State or foreign country) <i>Iowa</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>	Md			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) <i>Maryland</i>	13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Bethesda</i>	13d INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>7115 Exfair Road</i>			
14. FATHER'S NAME First <i>Frederick</i>	Middle <i>Wheeler</i>	Last <i>Conrad</i>	15. MOTHER'S MAIDEN NAME First <i>LENA</i>	Middle <i>Bethesda, Maryland</i>	Last <i>Conrad</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b SOCIA. SECURITY NO (If yes give war or dates of service) <i>377-10-2093</i>	17 INFORMANT <i>(Son) Glenn Lapham</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, fony whch gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF Trauma from fall (c) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis						13 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Fracture of left hip</i>						Years	
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>fall down stairs at home</i>	21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>1:00 am 8-24 1968</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) <i>Fell down stairs at home</i>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>	21f LOCATION Street or R.F.D. No <i>7115 Exfair Road</i>	City or Town <i>Bethesda</i>	County <i>Montg.</i>	State <i>Md.</i>		
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						22b DATE SIGNED <i>Sept. 6, 1968</i>	
ACTUAL SIGNATURE <i>Belden R. Peap</i>	CHIEF MEDICAL EXAMINER <i>M.D.</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>BELDEN R. PEAP</i>	ADDRESS <i>1420 Rockville Pike, Bethesda, Maryland</i>			ADDITIONAL INFORMATION (Address, city, town or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE <i>9-9-68</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>	23d LOCATION (City or Town) <i>Rockville, Maryland</i>	(County) <i>Maryland</i>	(State) <i>Maryland</i>		
24 FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	ADDRESS			25a REC'D BY REGISTRAR DATE <i>SEP 10 1968</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13194

13206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

IN FURNAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>HELEN</i>	Middle	Last <i>LEAMOND</i>	2d. DATE OF DEATH Month <i>SEPT</i> Day <i>27</i> Year <i>1968</i>	2b. HOUR <i>10 AM</i>
3. SEX <i>FEMALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>JAN 29, 1886</i>	6. AGE (In years last birthday) <i>82 yrs.</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>NEW YORK</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>MONTGOMERY</i>		
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>FAIRFIELD NURSING HOME</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>RETIRED SALESLADY</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>	13c. CITY OR TOWN <i>SILVER SPRING</i>	13d. IN DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>935 Bonfreet STREET</i>		
14. FATHER'S NAME First <i>JAMES</i>	Middle	Last <i>LEAMOND</i>	15. MOTHER'S MAIDEN NAME First Middle <i>MARY</i>	Last <i>O'SHEA</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>-0-</i>	16b. SOCIAL SECURITY NO <i>220-58-9896</i>	17. INFORMANT <i>CHARLES S. LEAMOND SAME AS 13a</i>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest -</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost. 420P</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>YRS</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Uremia</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>at home</i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>9/21</i> , 19 <i>68</i> , to <i>9/27</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9/21</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>R.T. Benack MD</i>	DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9/27/68</i>
22d. PHYSICIAN'S NAME (Type) <i>R.T. Benack MD</i>	22e. ADDRESS <i>4115 Colle Dr. Wheaton MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>SEPT. 30/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>GATE OF HEAVEN</i>	23d. LOCATION (City or Town) <i>SILVER SPRING MARYLAND</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Francis Collins</i>	ADDRESS <i>4748 Wren Court NW</i>	25a. REC'D. BY REGISTRAR DATE <i>OCT 1 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

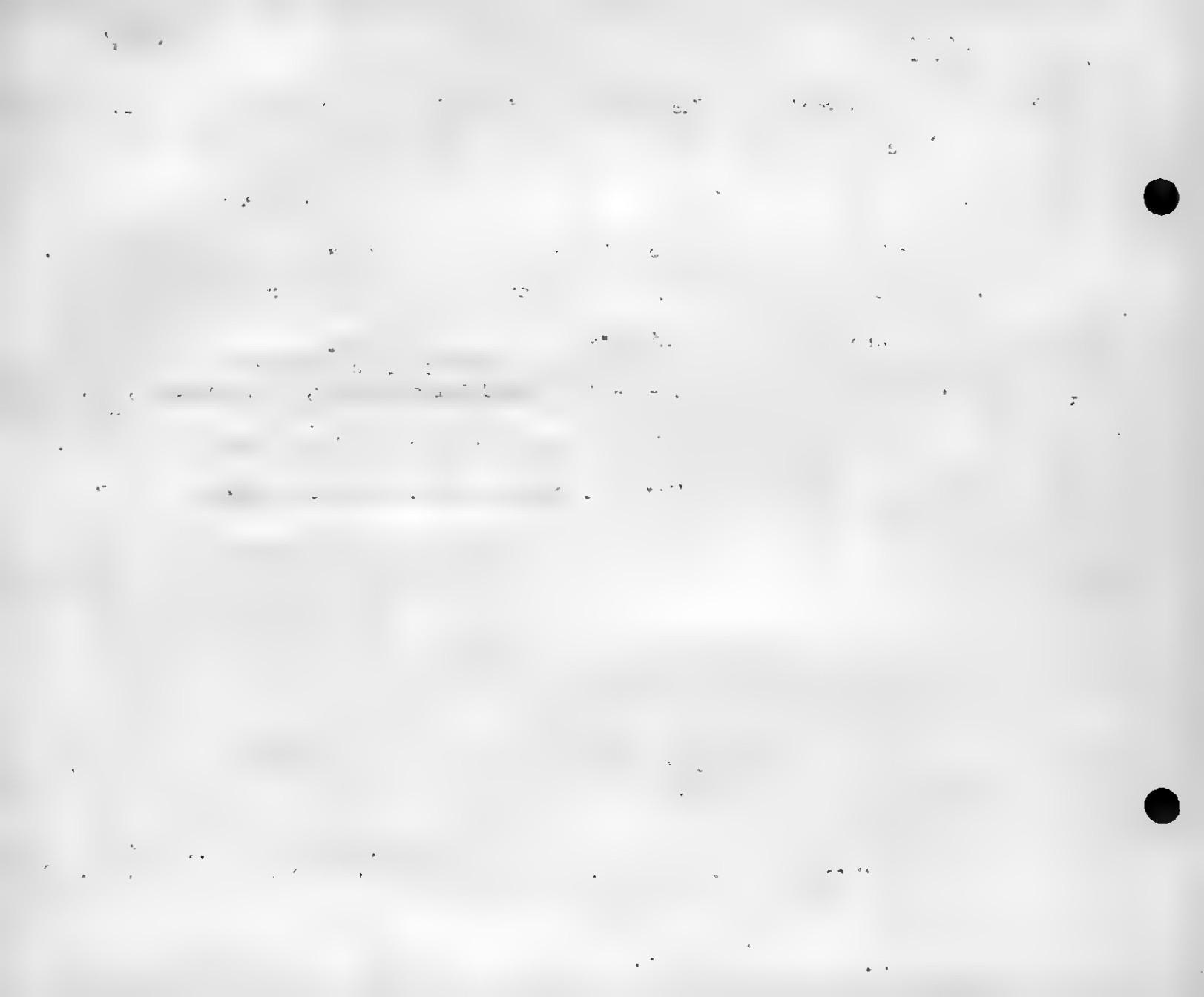
13207

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13195

1. DECEASED NAME (Type or print)	First Edward	Middle Theodore	Last Likowski	2a. DATE OF DEATH Month September	Day 24	Year 1968	2b. HOUR 12:30
3. SEX Male	4. RACE White	5. DATE OF BIRTH 12 June 1926			6. AGE (In years at birthday) 42	IF UNDER 1 YEAR MONTHS YRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Baking Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) New Jersey	13b. COUNTY Union	13c. CITY OR TOWN Linden	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 437 Rosewood Terrace			
14. FATHER'S NAME First John	Middle Likowski	Last 	15. MOTHER'S MAIDEN NAME First Josephine	Middle 	Last Prahogan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 152-14-5325	17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Hours		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock, circulatory insufficiency <i>510.1</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Idiopathic Hypertrophic Subaortic Stenosis DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. 	City or Town 	County 	State 	
22a. I certify that he (this hospital) attended the deceased from Sep 10 , 19 68 , to Sep 24 , 19 68 , that he (we) last saw the deceased alive on September 24 1968 , and that in no (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles L. McIntosh, MD		DEGREE MD	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 9/24/68	
22d. PHYSICIAN'S NAME (Type) Charles L. McIntosh, MD.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/27/68	23c. NAME OF CEMETERY OR CREMATORIAL Rosedale			23d. LOCATION (City or Town) Linden	(County) Union	(State) New Jersey
24. FUNERAL DIRECTOR Tyson Wheeler	1331 Rockville Rockville, Maryland	25a. REC'D BY REGISTRAR SEP 26 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13208

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Donald James Lindsay Sr.			Sept. 22 1968		
3. SEX Male	4. RACE White	S. DATE OF BIRTH Feb. 27, 1917	6. AGE (in years lost birthday) 51 yrs.		
7a. BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	Md.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PRINTER	12b. KIND OF BUSINESS OR INDUSTRY Newspaper
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 8702 Ridgeway Ave	
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Roscoe		Lindsay	Mabel		DONNELLY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes	16b. SOCIAL SECURITY NO. W.11	17. INFORMANT Mrs. Mary Lindsay	Address 8702 Ridgeway Ave Rockville, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4104</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , to <u>9-22-68</u> , that (I) (we) last saw the deceased alive on <u>8-20-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>William G. Hall</u>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>9-22-68</u>	
22d. PHYSICIAN'S NAME (Type) William G. Hall		22e. ADDRESS W. Montgomery Ave. Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/24/68	23c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery	23d. LOCATION (City or Town) Rockville, Maryland	(County)	(State)
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home	ADDRESS Rockville Printed BY REGISTRAR			25. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13197

13209

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First Kevin	Middle Matthew	Last LOCKHART	2a. DATE OF DEATH Month Sept.	Year 5	2b. HOUR 68				
3 SEX Male	4. RACE Caucasian	5. DATE OF BIRTH Sept. 4, 1968			6. AGE (in years last birthday) YRS.	IF UNDER 1 YEAR MONTHS 1	IF UNDER 24 HRS HOURS 1	MIN		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Montgomery						
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) N/A			12b. KIND OF BUSINESS OR INDUSTRY N/A					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia	13c. CITY OR TOWN Arlington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2623 S. Walter Reed Dr. Apt. 1							
14. FATHER'S NAME Cecil	First L.	Middle Lockhart	Last	15. MOTHER'S MAIDEN NAME Loretta	First Ann	Middle MOSES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. N/A	17. INFORMANT Dr. Apt. 1, Arlington, Virginia	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (1) SUB-DURAL HEMORRHAGE (2) BILATERAL PNEUMONITIS 17/10 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 18.										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 4, 1968, to Sept. 5, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 5, 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.										
22b. SIGNATURE B. JAY BORTZ, MD	DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	<input checked="" type="checkbox"/>	22c. DATE SIGNED Sept. 5, 1968					
22d. PHYSICIAN'S NAME (Type) B. JAY BORTZ MC, USN.	22e. ADDRESS Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-7-68	23c. NAME OF CEMETERY OR CREMATORIAL Highland Baptist Church Cemetery, Clanton, Alabama	23d. LOCATION (City or Town) (County) (State)							
24. FUNERAL DIRECTOR Robert A. Pumphrey	ADDRESS Funeral Home 7557 Wisconsin Ave., Bethesda, Md.	25a. REC'D BY REGISTRAR DATE SEP 10 1968	25b. REGISTRAR'S SIGNATURE j Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

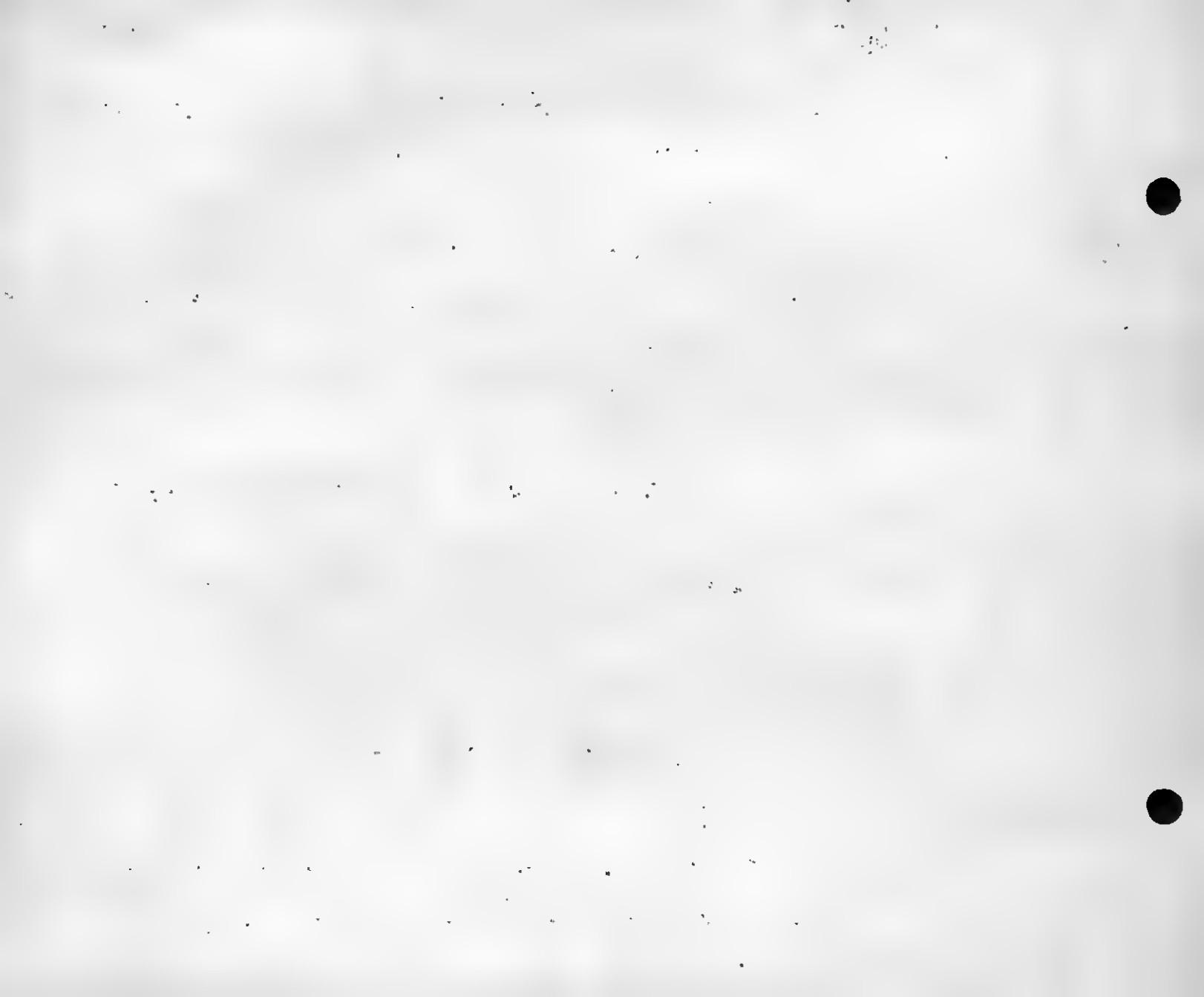
13210

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and 2 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
<i>Pauline C. B., Lombard</i>				<i>Sept</i>	<i>5</i>	<i>1968</i>	<i>2:30 P.M.</i>
3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
<i>Female</i>	<i>white</i>	<i>2-20-77</i>	<i>91</i> YRS.	MONTHS	DAYS	HOURS	MIN.
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH				
<i>Poland</i>	<i>American</i>		<i>Montgomery</i>				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
<i>Takoma Park</i>	<i>Washington Sanitarium & Hoop. -</i>			<i>Housewife</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER			
<i>Washington D.C.</i>		<i>Washington, D.C.</i>	<input checked="" type="checkbox"/>	<i>2801 Quebec Street, Apt 746</i>			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
			<i>Blumenthal</i>				<i>Unknown.</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address				
<i>No</i>	<i>578-40-3061</i>	<i>Records - Washington Sanitarium & Hoop. -</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							
PART 1. DEATH WAS CAUSED BY.							
IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause							
(b) <i>ARTERIOSCLEROTIC CARDIAC/ASCULAR DISEASE 10 years</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
<i>CEREBRO VASCULAR DISEASE - LEFT HEMIPLEGIA</i>							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert L. Krichmar</i>						22c. DATE SIGNED <i>SEPT 5 1968</i>	
22d. PHYSICIAN'S NAME (Type)	DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>9-9-68</i>	23c. NAME OF CEMETERY OR CEMETORY <i>ADAS ISRAEL CEM.</i>	23d. LOCATION (City or Town) <i>WASHINGTON</i>	(County) <i>DC</i>	(State)		
BURIAL							
24. FUNERAL DIRECTOR	ADDRESS <i>B. DANZANSKY & SONS. WASHINGTON DC</i>	25a. REC'D BY REGISTRAR DATE <i>SEP 10 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 405 MARYLAND STATE DEPARTMENT OF HEALTH
10-11-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
13190

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13211

1. DECEASED NAME (Type or Print)	First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
<i>Maryanna Loonis</i>				<input checked="" type="checkbox"/> Sept 21	1968	11:15	M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	F. UNDER 1 YEAR	IF UNDER 24 HRS				
<i>F</i>	<i>W</i>	<i>Sept 5, 1916</i>	<i>52 yrs.</i>	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH					
<i>New York</i>	<i>U.S.A.</i>	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	<i>Montgomery</i>					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY				
<i>Bethesda</i>	<i>Suburban Hospital Housewife</i>			<i>Bethesda</i>					
13. USUAL RESIDENCE (Where deceased lived, if not in hospital: admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
<i>Maryland Montgomery</i>	<i>Bethesda</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<i>7108 Beachwood Drive</i>					
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost		
<i>Frederick Whittlesey Oliver</i>				<i>Mary</i>	<i>Seelye</i>	<i>Hunter</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS <i>600 same</i>						
<i>No</i>	<i>-</i>	<i>Philip A. Loonis Jr. - husband</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i> Fatty metamorphosis of liver									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute alcoholism</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									22b. DATE SIGNED <i>Sept 22, 1968.</i>
ACTUAL SIGNATURE		<i>John G. Ball</i>							CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>John G. Ball</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town) (County) (State)		
<i>Cremation</i>		<i>9-24-1968</i>		<i>Cedar Hill Crematory</i>			<i>Suitland, Prince Georges Co., Md.</i>		
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.,</i>		ADDRESS <i>5130 Wisc.Ave. N.W., Wash., D.C., 20016</i>		25a. REC'D BY REG STRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15ME (5) 10M REV. 1/68				DATE <i>SEP 26 1968</i>					

8. 10. 2.

2. 1.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

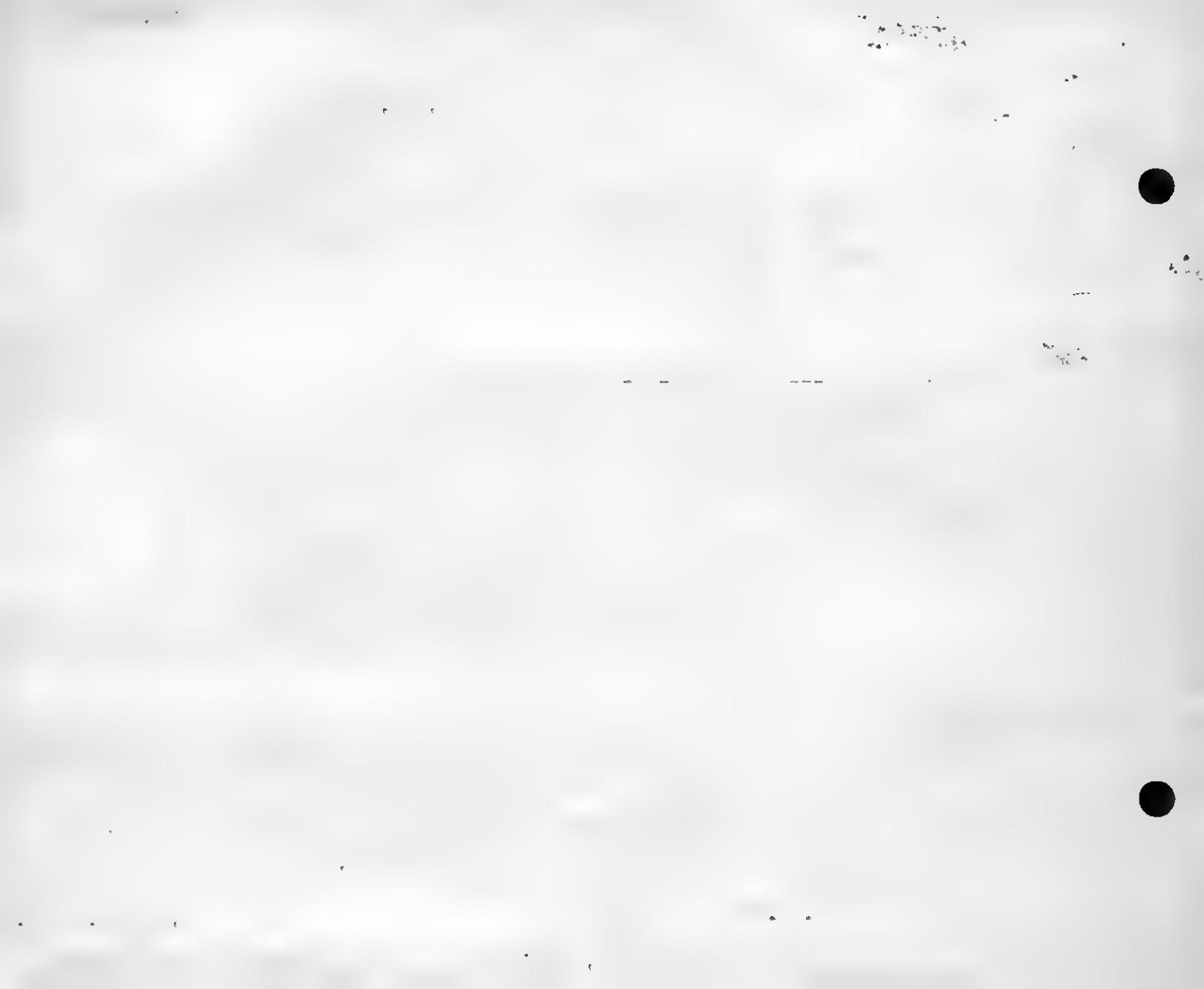
13212

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and refile with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) FRANCIS Leon	First	Middle	Last	2a. DATE OF DEATH Month 9 Day 27 Year 68	2b. HOUR
3 SEX Male	A RACE White	S. DATE OF BIRTH 9-3-1900	6. AGE (In years last birthday) 68 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
7a BIRTHPLACE (State or foreign country) Md - Modo	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban	12a. USUAL OCCUPATION (Kind of work done during life, even if retired) Retired	12b. KIND OF BUSINESS OR INDUSTRY McCrossen		
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.	13c CITY OR TOWN Mont. Darnestown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Box 90		
14. FATHER'S NAME First George S	Middle Lowey	15. MOTHER'S MAIDEN NAME First Virginia	Middle McCrosen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO 579-44-6363	17. INFORMANT wife Myrtle Lowey	Address Lane at home		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month					
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cadid renal failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. 476x (b) Hypertrophic Cardiomyopathy 3 years DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Prostatic hypertrophy					
19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) —	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) (OFFICE BUILDING, ETC.) —	21f. LOCATION Street or R.F.D. No. —	City or Town —	County —	State —
22a. I certify that (I) (this hospital) attended the deceased from June 1965 to Sept 26, 1968 , that (I) (we) last saw the deceased alive on Sept 25 1968 , one shot in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.					
22b. SIGNATURE John Fawcett	DEGREE JOHN FAWCETT	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9/27/68
22d. PHYSICIAN'S NAME (Type) JOHN FAWCETT	22e. ADDRESS Dawsonville, Maryland				
23a. FUNERAL CREMATION, REMOVAL REMOVED	23b. DATE 9/30/68	23c. NAME OF CEMETERY OR CREMATORIAL Darnestown	23d. LOCATION (City or Town) Darnestown, Montg. Md.	(County) —	(State) —
24 FUNERAL DIRECTOR TYSON WHEELER FUNERAL HOME	ADDRESS 1331 Rock Pike Rockville, Maryland	25a. REC'D BY REGISTRAR DATE SEP 30 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

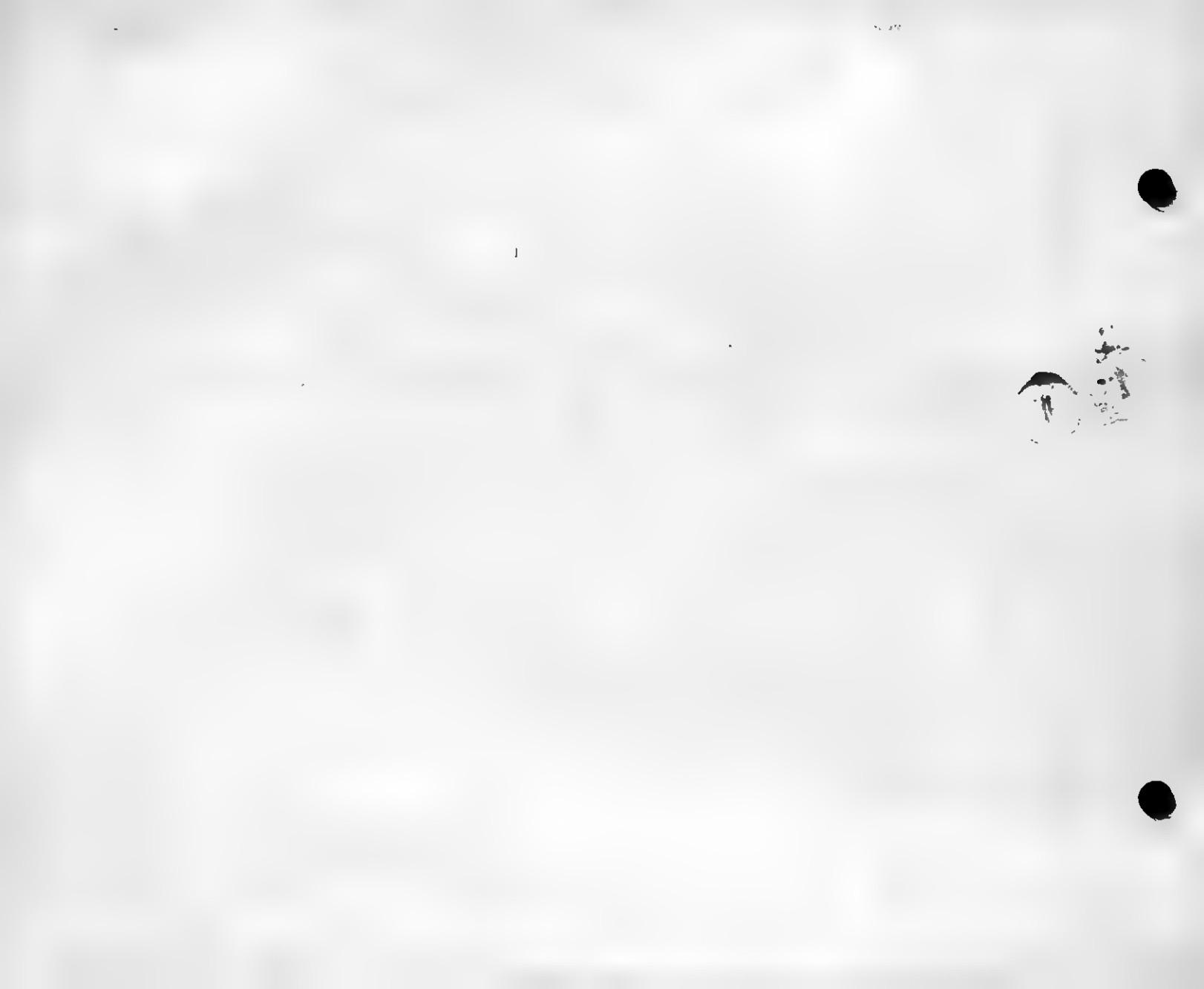
CERTIFICATE OF DEATH

13213

1. DECEASED NAME (Type or print)	First ANTOINETTE	Middle CORINNE	Last MACALUSO	2a. DATE OF DEATH Month 9 Day 20 Year 68	2b. HOUR M
3. SEX FEMALE	4 RACE WHITE	S. DATE OF BIRTH 1-29-86	5. AGE (In years last birthday) 82RS.	6. IF UNDER 1 YEAR MONTHS 0	7. IF UNDER 24 HRS HOURS 0
7a. BIRTHPLACE (State or foreign country) MAINE	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BUSINESS - RETIRED	12b. KIND OF BUSINESS OR INDUSTRY GIFT SHOP		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3600 GLENEAGLES DRIVE	
14. FATHER'S NAME First JOSEPH	Middle H.	Last GRONDIN	15. MOTHER'S MAIDEN NAME First ALPHONSINE	Middle -	Last DUPHAUX
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT MEDICAL RECORD DEPT.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute Myelocytic Leukemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 wks.					
2050 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 114					
19a. DATE OF OPERATION -	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 1966, 19, to Sept 20, 1966			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm Street, Factory Office Building, Etc.) OLNEY	21f. LOCATION Street or R.F.D. No. OLNEY	City or Town MD	County Montgomery	State MD
22a. I certify that (I) (this hospital) attended the deceased from Sept 19, 1966 , to Sept 20, 1966 , that (I) (we) last saw the deceased alive on Sept 19, 1966 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did <input checked="" type="checkbox"/> view the body after death.					
22b. SIGNATURE Richard A. Yates, M.D.	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9/20/68
22d. PHYSICIAN'S NAME (Type) R. A. YATES, M. D.	22e. ADDRESS OLNEY, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) 9/20/68	23b. DATE 9/20/68	23c. NAME OF CEMETERY OR CREMATORIAL GEO. WASH. UNIV. MED. SCHOOL 1335 H ST. N.W. WASH. D.C.	23d. LOCATION (City or Town) OLNEY	(County) MD	(State) DC
24. FUNERAL DIRECTOR Charles J. Carter	ADDRESS Assoc. Prof.	25a. REC'D BY REGISTRAR SEP 23 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13214

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First PAULINE	Middle E	Last MAGRUM	2a. DATE OF DEATH Month 9 Day 24 Year 68	2b. HOUR 4 PM
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH 2/21/06		6. AGE (In years last birthday) 62 YRS.	
7a. BIRTHPLACE (State or foreign country) D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Montgomery	10. CITY OR TOWN OF DEATH Silver Spring	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased lived at time of admission) Maryland	13b. INSTITUTION: Residence before admission Montgomery	13c. CITY OR TOWN Greenbelt	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 15-L Laurel Hill Rd.	
14. FATHER'S NAME James	First Middle Last H. Croson	15. MOTHER'S MAIDEN NAME Ella	P. Grimes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 578-12-0239	17. INFORMANT Francis M. Magnum	Address Greenbelt, Md. 15L Laurel Hill Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Carcinoma of Ovary</u> 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mos.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 11/20					
19a. DATE OF OPERATION 11/20		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <u>4/24/68</u> , to <u>4/24/68</u> , that (I) <u>saw</u> last saw the deceased alive on <u>4/24/68</u> , and that in my (<u>my</u>) opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (<u>did not</u>) view the body after death.					
22b. SIGNATURE <u>G. Lennard Gold</u>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 11/24/68
22d. PHYSICIAN'S NAME (Type) G. Lennard Gold		22e. ADDRESS Ga. & Forest Glen Rd. Sil. Spr. Md.			
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-27-1968	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Lincoln Cemetery		23d. LOCATION (City or Town) Prince Georges, Maryland	(County) Prince Georges, Maryland (State)
24. FUNERAL DIRECTOR Charles C. Glen Carter Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.		ADDRESS		25a. REC'D BY REGISTRAR Date SEP 27 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE
HEALTH DEPT.

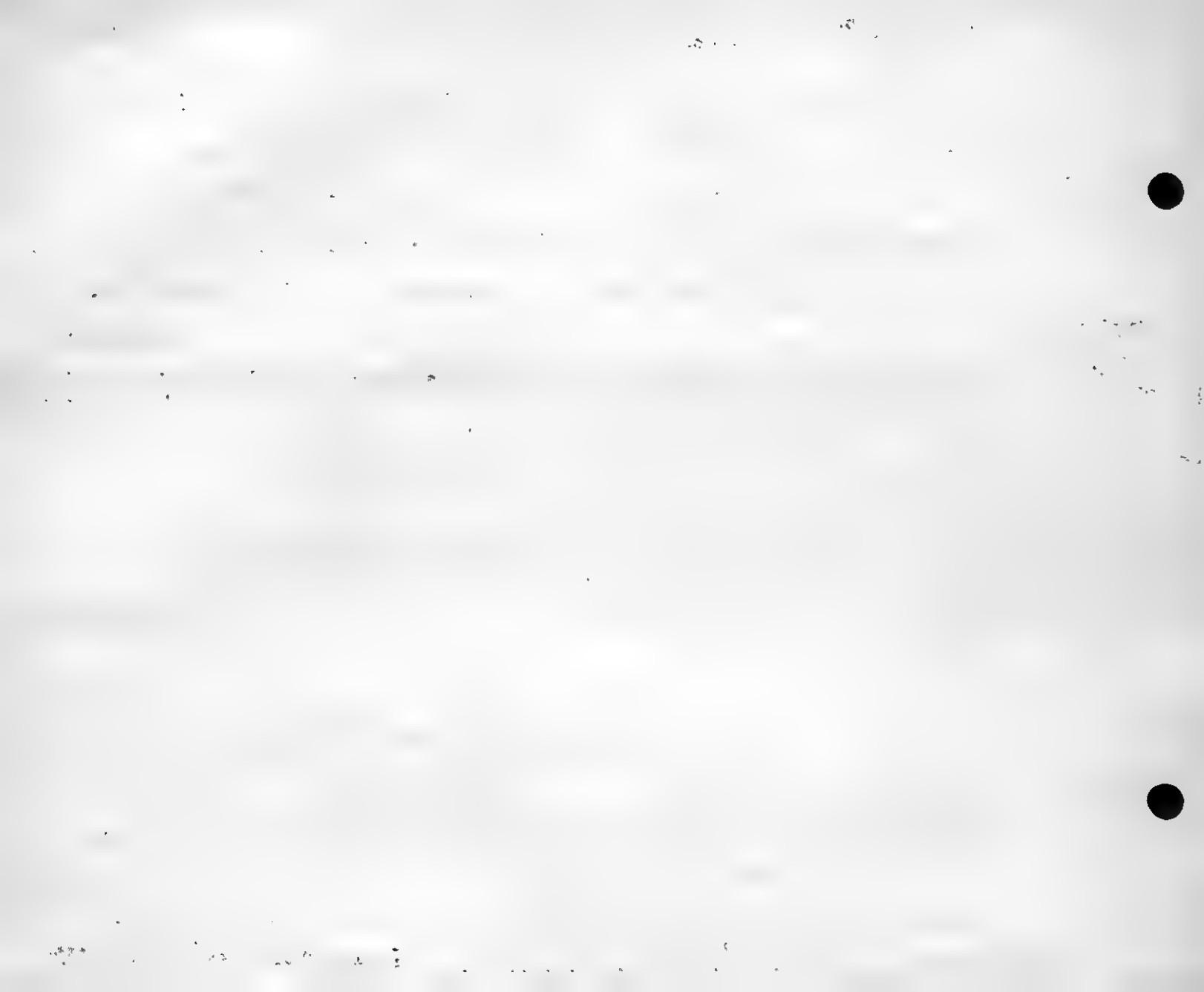
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13203 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13215

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH MATED	Month	Day	Year	2b HOUR	
Norman			Aloysius	Marceron		<input checked="" type="checkbox"/>	Sept 18	1968		8P M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	F. UNDER 24 HRS DAYS	HOURS	MIN				
Male	Cau	June 20 1905	63 yrs								
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2c DATE PRONOUNCED DEAD Month Day Year			
Washington, D. C. USA				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		Sept 18 1968			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hsp.			Ass't. Hoc.			U.S. Gov't.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Montgomery Silver Sprx						10513 Proctor St.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Julian Marceron			Lillian								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			493-20-6322			Catherine G. Marceron			10513 Proctor St., S. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Dystrophy Acute</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <i>Coronary arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Parkinsonism</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											22b DATE SIGNED
ACTUAL SIGNATURE <i>John G. Ball</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			9/19/68		
EXAMINER'S NAME (Type)			John G. Ball								
23a BURIAL/CREMATON, REMOVAL (Specify)			23b DATE Sept. 23, '68			23c NAME OF CEMETERY OR CREMATORIUM Gate of Heaven			23d LOCATION (City or Town) (County) (State)		
Burial									Sil. Spr. Montg. Maryland		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
M. Andrew Dubow			Andrew Dubow						Charles Judge		
Warren E. Pumphrey, Inc. 8434 Ga. Ave. S.S., Md.						DATE SEP 25 1968					



FOR STATE
HEALTH DEPT.

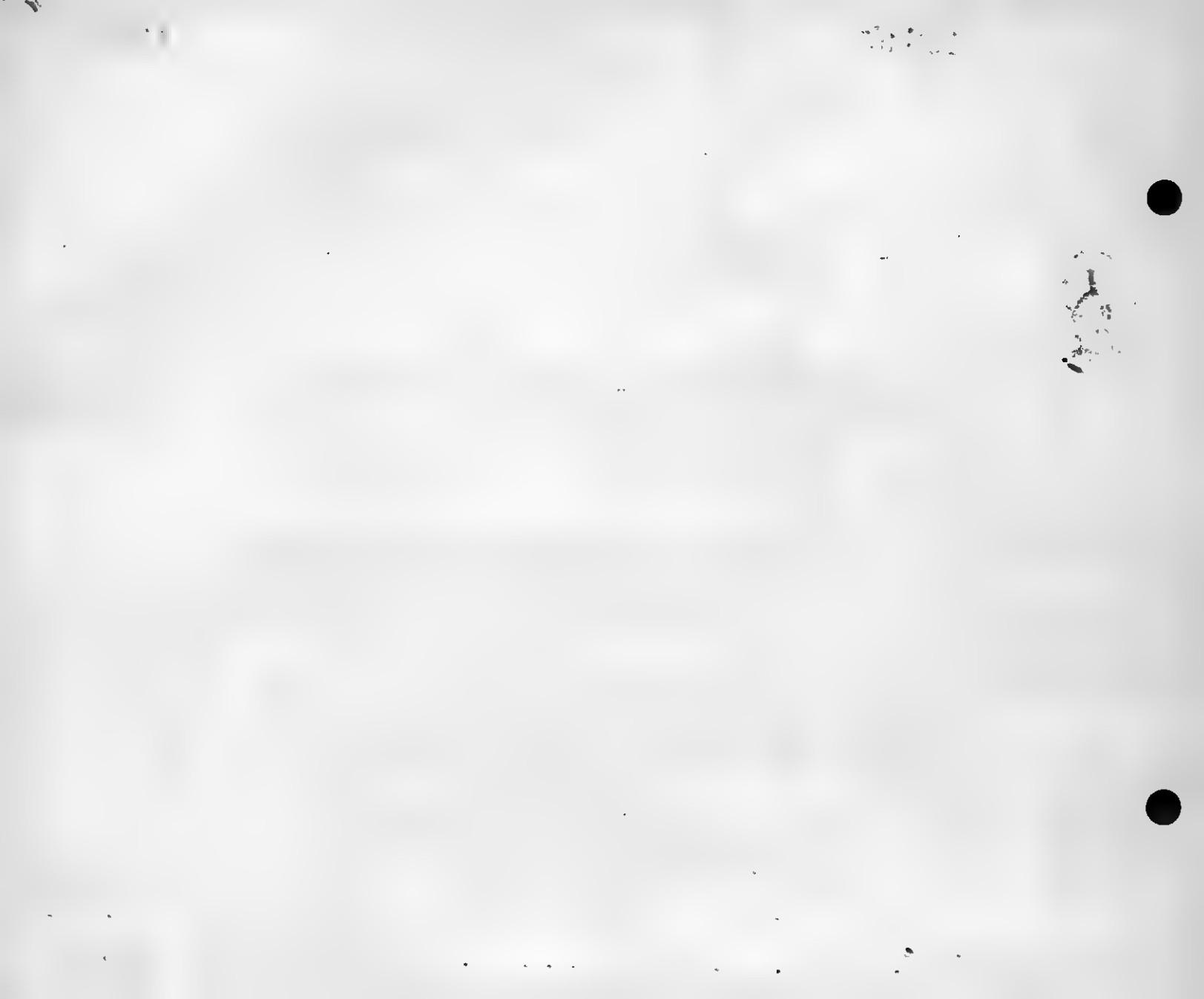
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13216

1 DECEASED NAME (Type or Print)		First <i>Charles</i>	Middle <i>William</i>	Last <i>Mayn</i>	2a DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	Month <i>Sept</i>	Day <i>15</i>	Year <i>1968</i>	2b HOUR <i>2 P.M.</i>				
3 SEX <i>M.</i>	4 RACE <i>W.</i>	5 DATE OF BIRTH <i>11/25/1910</i>	6 AGE (in years last birthday) <i>57 yrs</i>	7 IF UNDER 1 YEAR MONTHS <input type="checkbox"/>	8 IF UNDER 24 HRS DAYS <input type="checkbox"/>	9 IF UNDER 24 HRS HOURS <input type="checkbox"/>	10 MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month <i>Sept</i>	Day <i>15</i>	Year <i>1968</i>	2d HOUR <i>2 P.M.</i>		
7a BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		10 CITY OR TOWN OF DEATH <i>Silver Spring</i>			
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>		12a JSAI OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Salesman</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Bakery</i>		13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13c CITY OR TOWN <i>Montgomery Silver Spring</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>10114 Greenock Rd.</i>	
14 FATHER'S NAME First <i>Charles Edward</i>		Middle <i></i>	Last <i>Mayn</i>	15 MOTHER'S MAIDEN NAME First <i>Adrienne Bell Snoots</i>		Middle <i></i>	Last <i></i>	16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO <i>577-09-7394</i>		17 INFORMANT <i>Eva Mayn - same as pt.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Laceration + Contusion of Brain.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i></i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hr.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) b) <i>Fracture of skull from trauma from fall</i> DUE TO, OR AS A CONSEQUENCE OF (c)													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?									
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR AM <i>1230 PM 9/15 1968</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell off ladder working on roof of house</i>									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>House</i>		21f LOCATION Street or R.F.D. No City or Town <i>10114 Greenock Rd. Silver Spring Montgomery</i>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>Sept. 15, 1968</i>									
EXAMINER'S NAME (Type) <i>John G. Ball</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
		ADDRESS (Street, city, town, or county) <i></i>											
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Kirks</i>		23b DATE <i>9-20-68</i>		23c NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Parklawn Cemetery</i>									
24 FUNERAL DIRECTOR <i>Carter</i>		25a REC'D BY REGISTRAR <i>SEP 20 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

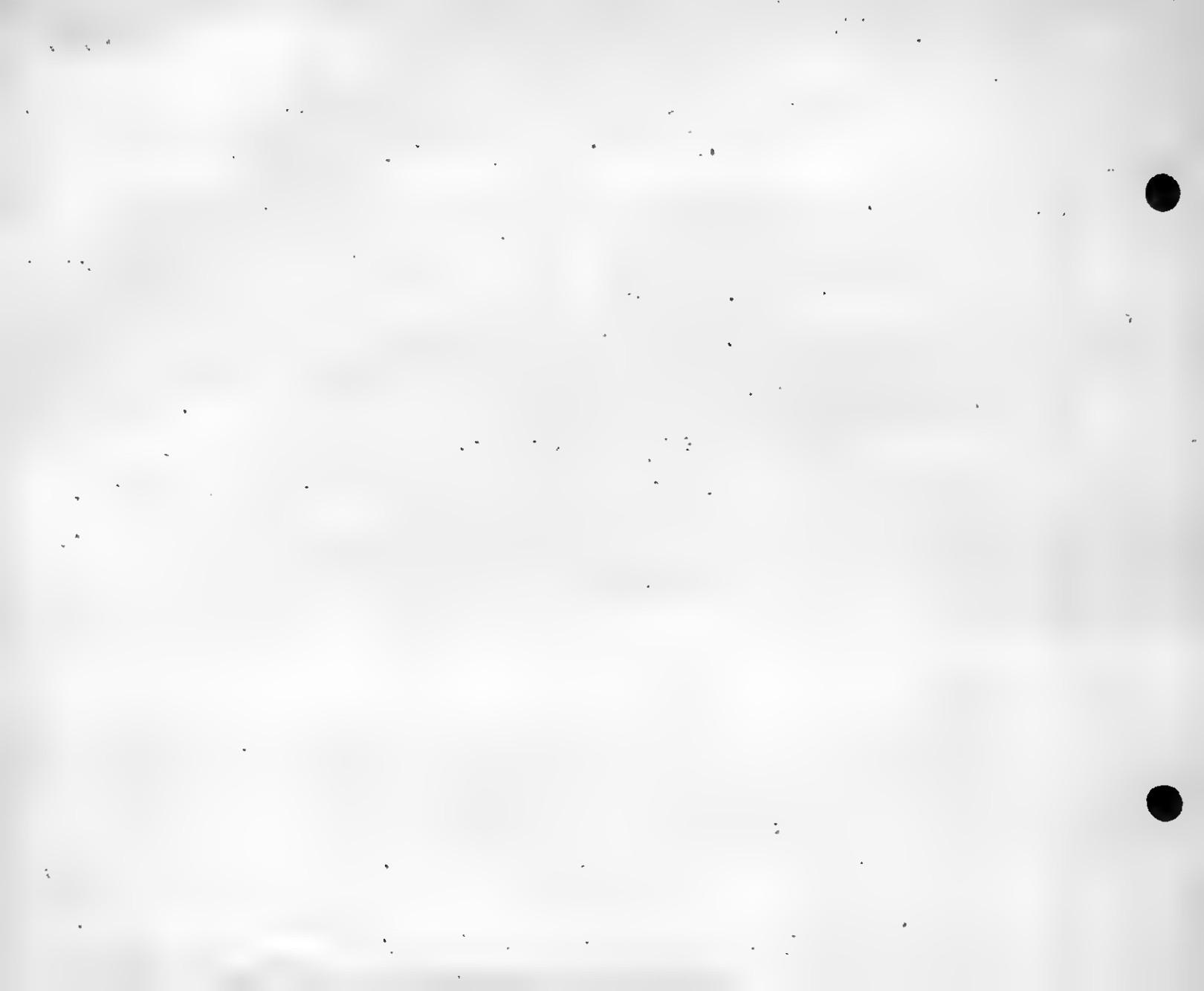
CERTIFICATE OF DEATH

13217

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 from this certificate, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 from this certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Thomas</i>	Middle <i>E.</i>	Last <i>McCalley</i>	2a. DATE OF DEATH Month <i>September</i>	Day <i>28</i>	Year <i>1968</i>	2b. HOUR <i>11:15 AM</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>9/25/92</i>		6. AGE (in years last birthday) <i>76</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Randolph Hills N.H.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Railroad Engineer</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Transportation</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Takoma Park</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>7711 Greenwood Ave.</i>					
14. FATHER'S NAME First <i>James</i>	Middle <i>Zem</i>	Last <i>McCalley</i>	15 MOTHER'S MAIDEN NAME First <i>Nanee</i>	Middle <i>Stay</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>WWI</i>	17. INFORMANT <i>Albert Lenwood McCalley</i>	Address <i>Albert Lenwood McCalley</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>							<i>2 hrs</i>		
4317 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>last, 331x</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i>							<i>4 yrs</i>		
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus, Prostatic Hypertrophy</i>									
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>10/10/68</i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Colman Manor</i>	21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>10/10/68</i> , to <i>10/28/68</i> , that (I) (we) last saw the deceased alive on <i>9/28/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R.T. Benack MD</i>									
22c. DATE SIGNED <i>9/28/68</i>									
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <i>4115 Cole Drive, Wheaton, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Oct. 1, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>	23d. LOCATION (City or Town) <i>Colman Manor</i>	(County) <i>Md.</i>	(State) <i>Md.</i>				
24. FUNERAL DIRECTOR <i>John K. Kilkenny Washington DC 20012</i>	ADDRESS <i>2517 Georgia East, N.W.</i>	25a. REG'D BY REGISTRAR <i>OCT 2 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

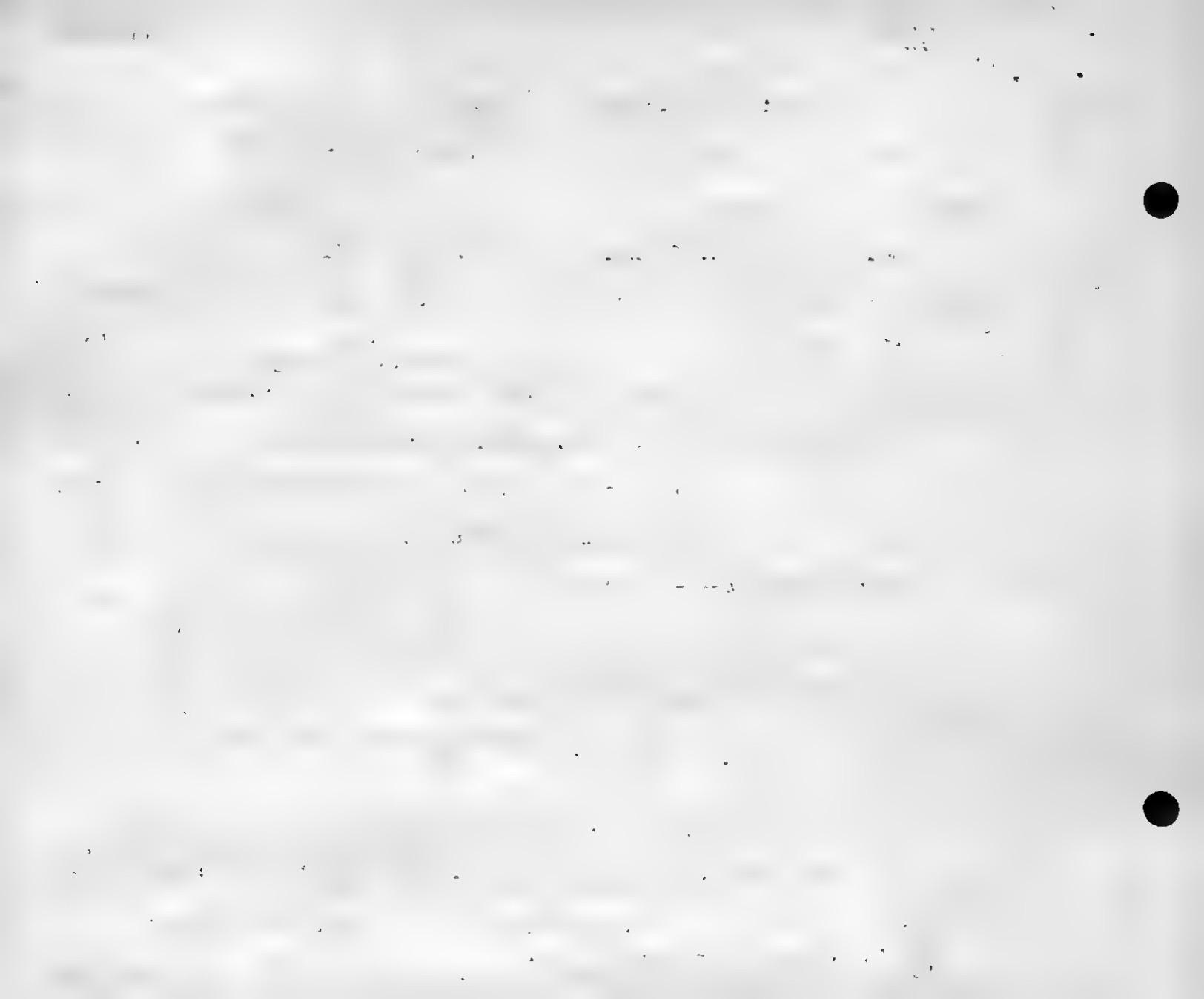
13218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	2b. HOUR		
Bridget			DeVonne	McCoy	Month Day Year	September 22, 1968	6:30 AM		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		Negro		November 28, 1962		5		MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		IF UNDER 24 HRS HOURS MIN.	
Maryland		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		The Clinical Center, NIH		Child		---			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince Georges		North Brentwood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3909 Webster Street	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
		Unknown					Hilda		McCoy
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT The Medical Record Address					
No		None		The Clinical Center, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bacterial endocarditis of aortic valve</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emboli to kidneys, left external iliac artery</u> 10 days									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Interventricular septal defect</u> 5 Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Bronchopneumonia----(i month)</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
								22	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from September 21, 1968, to September 22, 1968, that <input type="checkbox"/> (we) los saw the deceased alive on September 22, 1968, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert Mason MD</u> 22c. DATE SIGNED 9/22/68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		The Clinical Center, National Institutes of Health, Bethesda, Md.					
Robert Mason, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County) (State)	
Burial		9-25-68		Lincoln Memorial		Suitland, Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John T. Rhines Company Funeral Home 3015 12th Street, N. E., Washington, D. C.									
				DATE SEP 26 1968					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13219

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Henry	Middle T.	Last MCCURDY III	2a. DATE OF DEATH Month Sept	Day 16	Year 68	2b. HOUR 245 P M
3 SEX Male	4 RACE Cauc	5. DATE OF BIRTH May 19, 1968		6. AGE (In years last birthday) — yrs.	IF UNDER 1 YEAR MONTHS 3	IF UNDER 24 HRS. DAYS 27	IF UNDER 24 HRS. HOURS — MIN.
7a. BIRTHPLACE (State or foreign country) Florida	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Florida	13b. COUNTY	13c. CITY OR TOWN Pensacola	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 3005 N. P Street			
14. FATHER'S NAME Henry	First T.	Middle MCCURDY, Jr.	Last Mary	15. MOTHER'S MAIDEN NAME Alice	Middle HOPKINS	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown N/A	16b. SOCIAL SECURITY NO. N/A	17. INFORMANT Pensacola Henry T. McCurdy, Jr.		Address Florida 3005 N. P Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status post operative cardiac surgery for congenital pulmonary valve atresia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 754.5							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY <input checked="" type="checkbox"/> limited	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from Sept. 10, 1968, to Sept. 16, 1968, that <input type="checkbox"/> (we) last saw the deceased alive on Sept. 10, 1968, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>William R. Hicks</i>		DEGREE ATTEND.NG PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Sept. 17, 1968		
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS William R. Hicks, M. D.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/17/68	23c. NAME OF CEMETERY OR CREMATORIUM Barrancas National Cemetery	23d. LOCATION (City or Town) Pensacola, Florida		(County)	(State)	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.	ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 20 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

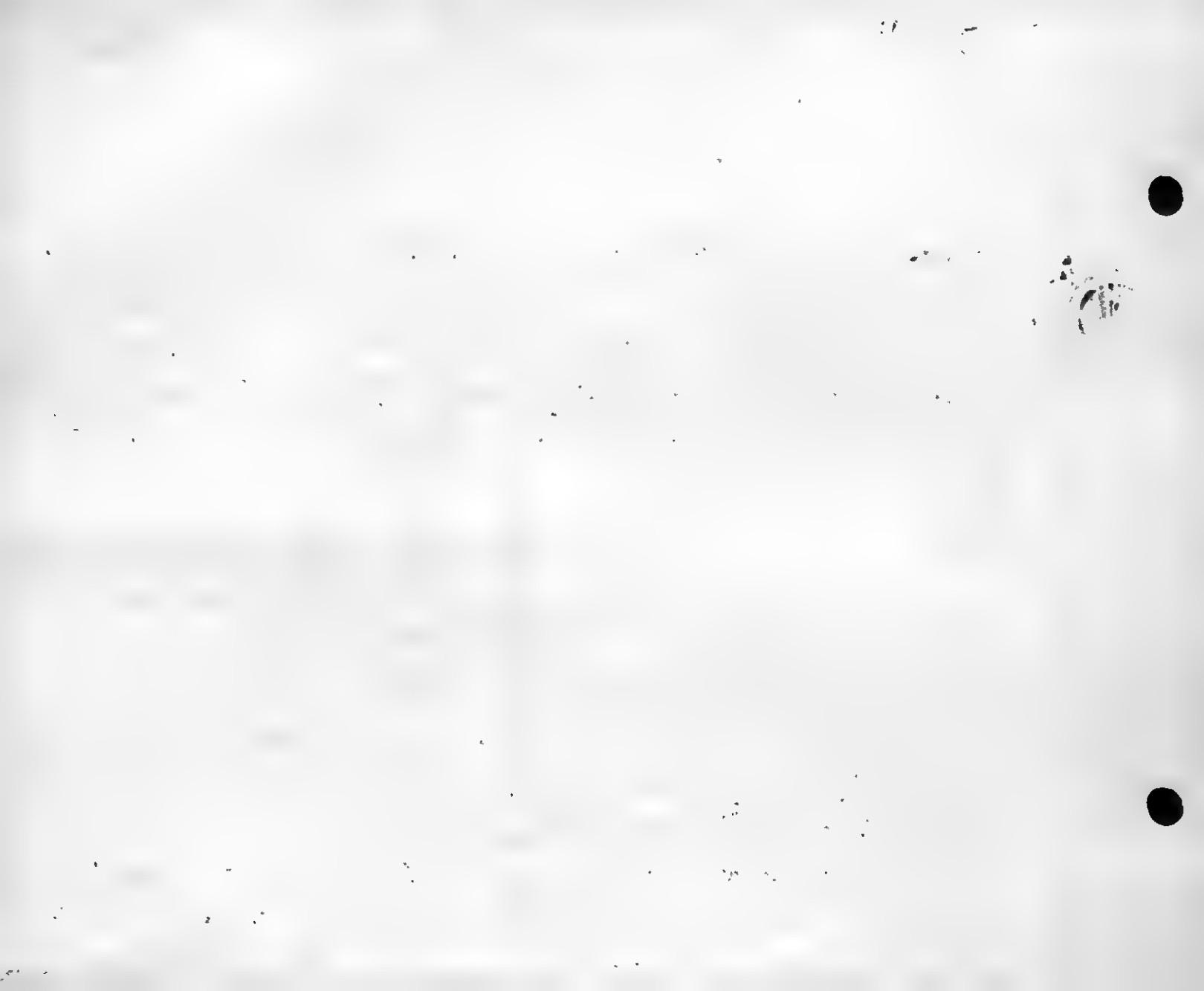
13208

13220

1. DECEASED-NAME : First (Type or print) Frank			Middle Lee	Last McGuffin	2a. DATE OF DEATH Month Sept 19 1968	2b. HOUR 10 a.m.			
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 4/24/1898	6. AGE (in years last birthday) 70 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 1 M.N. HOURS 0			
7a. BIRTHPLACE (State or foreign country) Oklahoma	7b. CITIZEN OF WHAT COUNTRY? USA	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Photographer (RETIRED)	12b. KIND OF BUSINESS OR INDUSTRY US GOVT.					
13a. US/JAL RESIDENCE (Where deceased admission) STATE Virginia	13b. COUNTY Alexandria	13c. CITY OR TOWN Alexandria	13d. INSIDE CITY, M.F.T.P. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4600 Duke Street					
14. FATHER'S NAME First George	Middle William	Last McGuffin	15. MOTHER'S MAIDEN NAME First Lucy	Middle MAST	Last MAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO (If yes give war or dates of service) World War I	16c. INFORMANT SELINA V. McGUFFIN SAME AS 15(3E)	Address Montgomery						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Globastoma Multiforme</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED While at work Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that (I) (this hospital) attended the deceased from 8-18 , 19 68 , to 9-18 , 19 68 , that (I) (we) last saw the deceased alive on 8-18-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Thomas N. Carter</i>		22c. DATE SIGNED 1968							
22d. PHYSICIAN'S NAME (Type) THOMAS N CARTER	22e. ADDRESS 1835 EYE ST NW. WASH D.C.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-23-68	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATL CEM	23d. LOCATION (City or Town) (County) BALTIMORE MD						
24. FUNERAL DIRECTOR W.W. Chambers Co Silver Spring Md.	ADDRESS	25a. REC'D. BY REGISTRAR DATE SEP 26 1968	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please, ~~return to~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13209

13221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be retained by the hospital or attending physician. This certificate should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM PM
<i>Romarico</i>			<i>NONE</i>	<i>MENDOZA</i>	9 4 1968	7 49	
3. SEX MALE		4. RACE WHITE	5. DATE OF BIRTH 5-3-00			6. AGE (In years lost birthday) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) CUBA		7b. CITIZEN OF WHAT COUNTRY? CUBAN	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH TAKOMA Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. & HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN TAKOMA Park	13d. INSIDE CITY LIMIT YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8719 Piney Branch Apt. 4		
14. FATHER'S NAME ROMARICO		Middle MENDOZA	15. MOTHER'S MAIDEN NAME MARIA	Middle VELARDE	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. -	17. INFORMANT HOSPITAL RECORDS, TAKOMA Park, MARYLAND	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
		DUE TO, OR AS A CONSEQUENCE OF (b) <i>malignant cachexia</i>			<i>1 year</i>		
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>multiple myeloma</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Anemia.							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 10, 1968</u> , to <u>Sept. 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept. 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. Velarde</i>		DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Sept. 4, 1968</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS WASH. SANT. AND HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-6-1968	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery			23d. LOCATION (City or Town) Bladensburg, Prince George's Co., Md.	(County) Co., Md.
24. FUNERAL DIRECTOR Joseph Gowler's Sons, Inc., N.W., Wash., D.C., 20016		ADDRESS 5130 Wisc. Ave.	25a. REC'D BY REGISTRAR SEP 9 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MURRAY

13210

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13222



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner

MEDICAL CERTIFICATION

1. DECEASED NAME (Type or print)	First ANNA	Middle S.	Last MERREY	2a. DATE OF DEATH Month Sept. 18 Year 1968	2b. HOUR 10:34 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH July 26, 1884		6. AGE (In years last birthday) 84	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Union, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S.	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before death) NO. 217 West Main St.	13b. COUNTY CECIL	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 217 West Main St.		
14. FATHER'S NAME JACOB	First ELLIS	Middle Potts	Last	15. MOTHER'S MAIDEN NAME Margaret ANN	Middle	Last McCREA
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 318-32-2774	17. INFORMANT Hugh Harvey, 4016 Havard St. Sil. Sp., Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>OCCULTION RIGHT CORONARY ARTERY</u>				2 HRS		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ATHEROSCLEROSIS</u>				5 YRS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22o. I certify that (I) (this hospital) attended the deceased from APRIL 1967, to SEPTEMBER 16, 1968, that (I) <input type="checkbox"/> last saw the deceased alive on SEPT 16 1968, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.						
22b. SIGNATURE Edward A. Beeman	M.D. DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED SEPT 16, 1968	
22d. PHYSICIAN'S NAME (Type) EDWARD A. BEEMAN	22e. ADDRESS 1015 SPRING ST. SILVER SPRING MD 20910					
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial	23b. DATE 9/20/68	23c. NAME OF CEMETERY OR CREMATORIAL ELKTON	23d. LOCATION (City or Town) ELKTON	(County) CECIL	(State) MD	
24. FUNERAL DIRECTOR Robert Fawcett	ADDRESS PIPPIN FUNERAL HOME	25a. REC'D BY REGISTRAR Date SEP 19 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

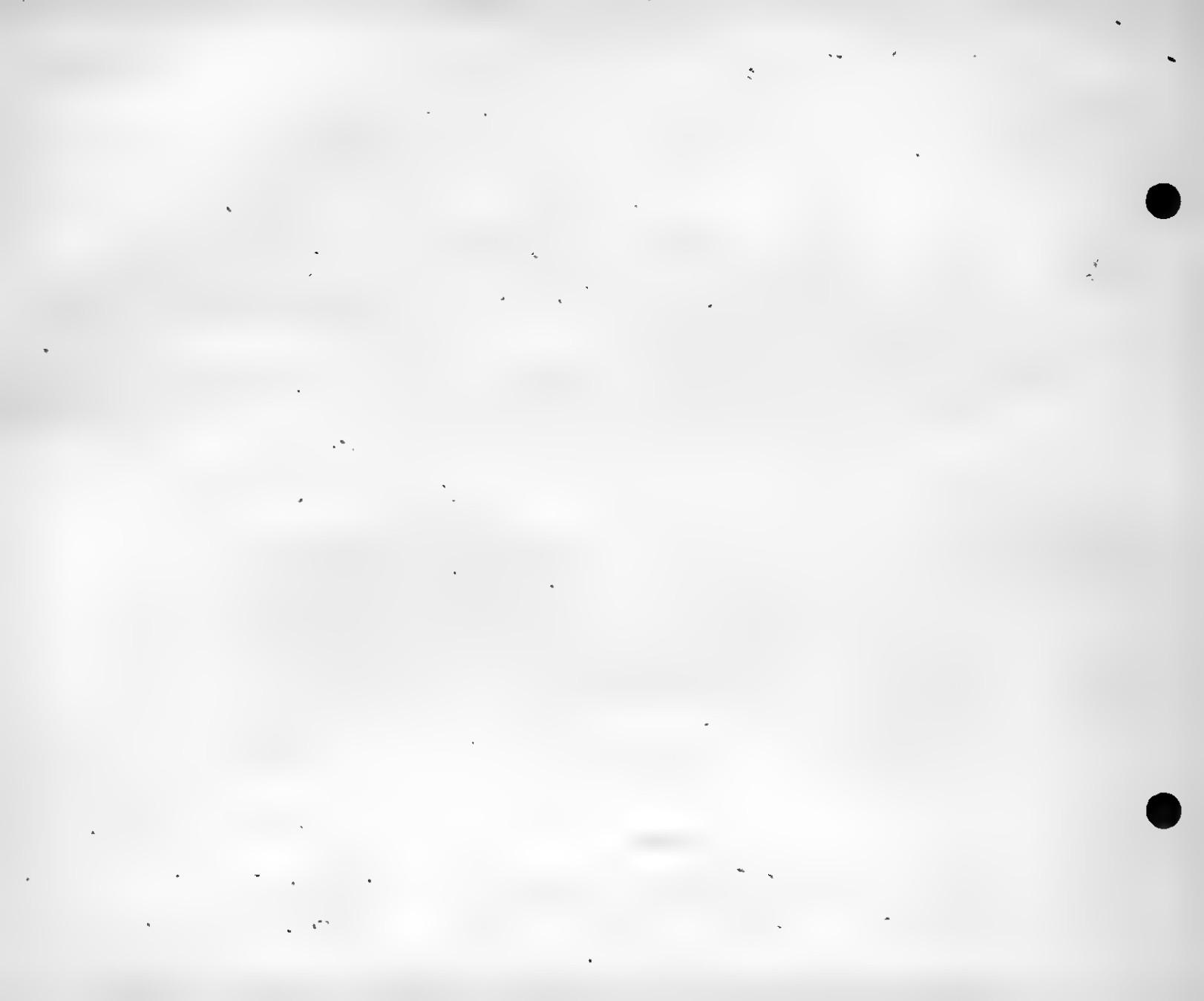
13211

13223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for us as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>DESSIE</i>	Middle <i></i>	Last <i>METCALF</i>	2a DATE OF DEATH Month <i>Sept</i>	Day <i>2</i>	Year <i>1968</i>	2b HOUR <i>11 P.M.</i>		
3. SEX <i>Female</i>	4. RACE <i>white</i>	S. DATE OF BIRTH <i>11/15/79</i>	5. AGE (In years last birthday) <i>8</i>	6. IF UNDER YEAR MONTHS <i>YRS.</i>	7. IF UNDER 24 HRS. MONTHS <i></i>	8. IF UNDER 24 HRS. DAYS <i></i>	9. IF UNDER 24 HRS. HOURS <i></i>		
7a BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>						
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	12b KIND OF BUSINESS OR INDUSTRY <i>Art 1919</i>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13c CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <i>1131 University Blvd. West.</i>						
14. FATHER'S NAME First <i>Johnathon</i>	Middle <i>J.</i>	Lost <i>Cole</i>	15. MOTHER'S MA.DEN NAME First <i>Minnie</i>	Middle <i></i>	Lost <i>Curry</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>230-40-3699</i>	17. INFORMANT <i>Daughter Mrs. M. Richardson</i>	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal obstruction</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1537 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Diverticulitis & intestinal hemorrhage</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Toxins of bowel - carcinom</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diverticulitis & intestinal hemorrhage</i>									
19a. DATE OF OPERATION <i>8/27/68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal Obstruction</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i>Not applicable</i>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.) <i></i>	21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>				
22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , 19, to <i>present</i> , 19, that (I) (we) last saw the deceased alive on <i>9/2</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John B. Upton MD</i>						ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9/3/68</i>
22d. PHYSICIAN'S NAME (Type) <i>John B. Upton</i>	22e. ADDRESS <i>5805 Concourse Ave. Chevy Chase MD</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>9-5-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i></i>	23d. LOCATION (City or Town) <i>Lakota, North Dakota</i>	(County) <i></i>	(State) <i></i>				
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 3130 Wisc. Ave. N.W., Wash., D.C.</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i>SEP 6 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with arm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
13212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13224

1. DECEASED-NAME (Type or Print)	First Elwood	Middle Herbert	Lost Missimer	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 9	Day 8	Year 68	2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9/4/12	6. AGE (in years last birthday) 56 yrs	F UNDER 1 YEAR MONTHS GAYS HOURS MIN	IF UNDER 24 HRS			2c. DATE PRONOUNCED DEAD Month 9 Day 8 Year 68	2d. HOUR M
7a. BIRTHPLACE (State or foreign country) Reading, Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH Silver Spring, Md.	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Auditor			12b. KIND OF BUSINESS OR INDUSTRY Private		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b. COUNTY Prince Geo.	13c. CITY OR TOWN Beltsville	13d. INSIDE CITY LIMIT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 11412 Cherry Hill Rd.					
14. FATHER'S NAME First Herbert	Middle Missimer	15. MOTHER'S MAIDEN NAME Emma	16. SOCIAL SECURITY NO 170-07-7342	17. INFORMANT Dolores Missimer/wife	ADDRESS 11412 Cherry Hill Rd. Belt			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</p> <p>(b) Due to, or as a consequence of Coronary Artery Heart Disease</p> <p>(c)</p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)</p> <p>425-1</p>									
19a. DATE OF OPERATION 425-1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No		City or Town	County	State		
<p>22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>									
<p>ACTUAL SIGNATURE BELDEN R. LEAP, M.D., EXAMINER'S NAME (Type)</p>									
<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, town, city or county) SEPT. 8, 1968</p>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 11, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Schwarzwald Cemetery	23d. LOCATION (City or Town) Exeter Township Berks, Penna.	(County)	(State)				
24. FUNERAL DIRECTOR M. Andrew Dwall Warner E. Pumphrey Inc.	ADDRESS 8434 Ga. Ave. S.S., Md.	25a. REC'D BY REGISTRAR SEP 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

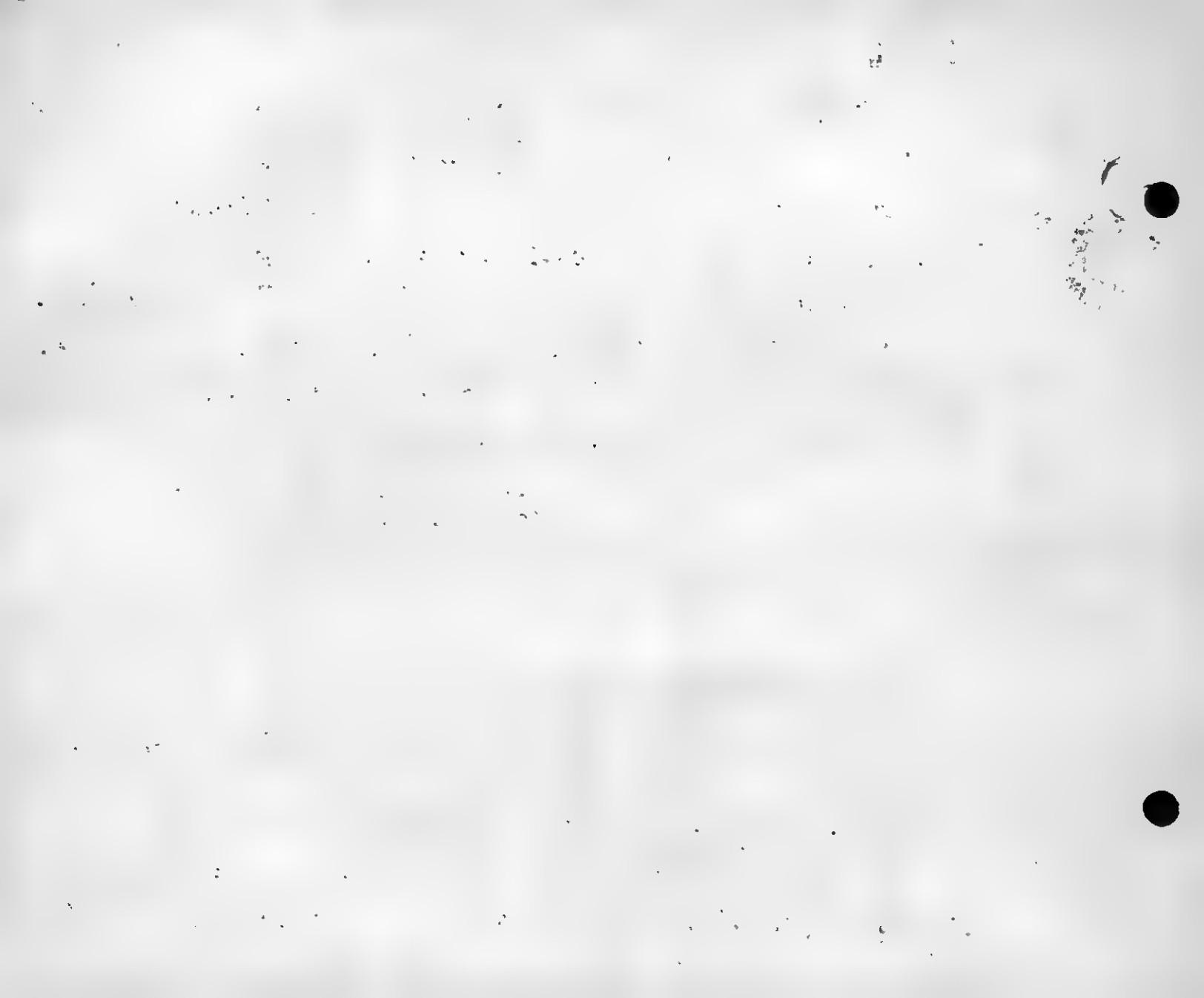
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from page 2 and 3, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CLEARED WITH MEDICAL EXAMINER

13213			13225				
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR Hour Min	
FRANCIS ELIZABETH MOORE					9 7 68	6:53 A M	
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years old birthday) YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
FEMALE		WHITE	December 23, 1896		68 yrs		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		MONTGOMERY USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTGOMERY		Md.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
TAKOMA PARK		WASHINGTON SAN + HOSP. HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adoption) STATE		13b. COUNTY	13c. CITY OR TOWN		13d. STREET AND NUMBER		
MARYLAND			TAK. PARK		7113 CARROLL AVE.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle
ALBERT -				MILES	ELIZABETH		MOORE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address	
NO		579-01-4278		HOSPITAL RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <i>Renal Insufficiency</i>							
4120 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause							
(b) <i>Hypertension arteriosclerotic Cardiovascular Disease</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <i>Vascular Disease</i>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 9-5, 1968, to 9-7, 1968, that (I) (we) last saw the deceased alive on 9-7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Bernard A. Fitzgerald MD</i>							
DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED 9-7-68							
22d. PHYSICIAN'S NAME (Type)		BERNARD A. FITZGERALD		22e. ADDRESS		22f. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town) (County) (State)	
Burial		Sept. 10, 1968		Union Cemetery		Burtonsville, Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Arthur Walters, 254 Carroll St NW, D.C.				SEP 10 1968		Charles Judge	



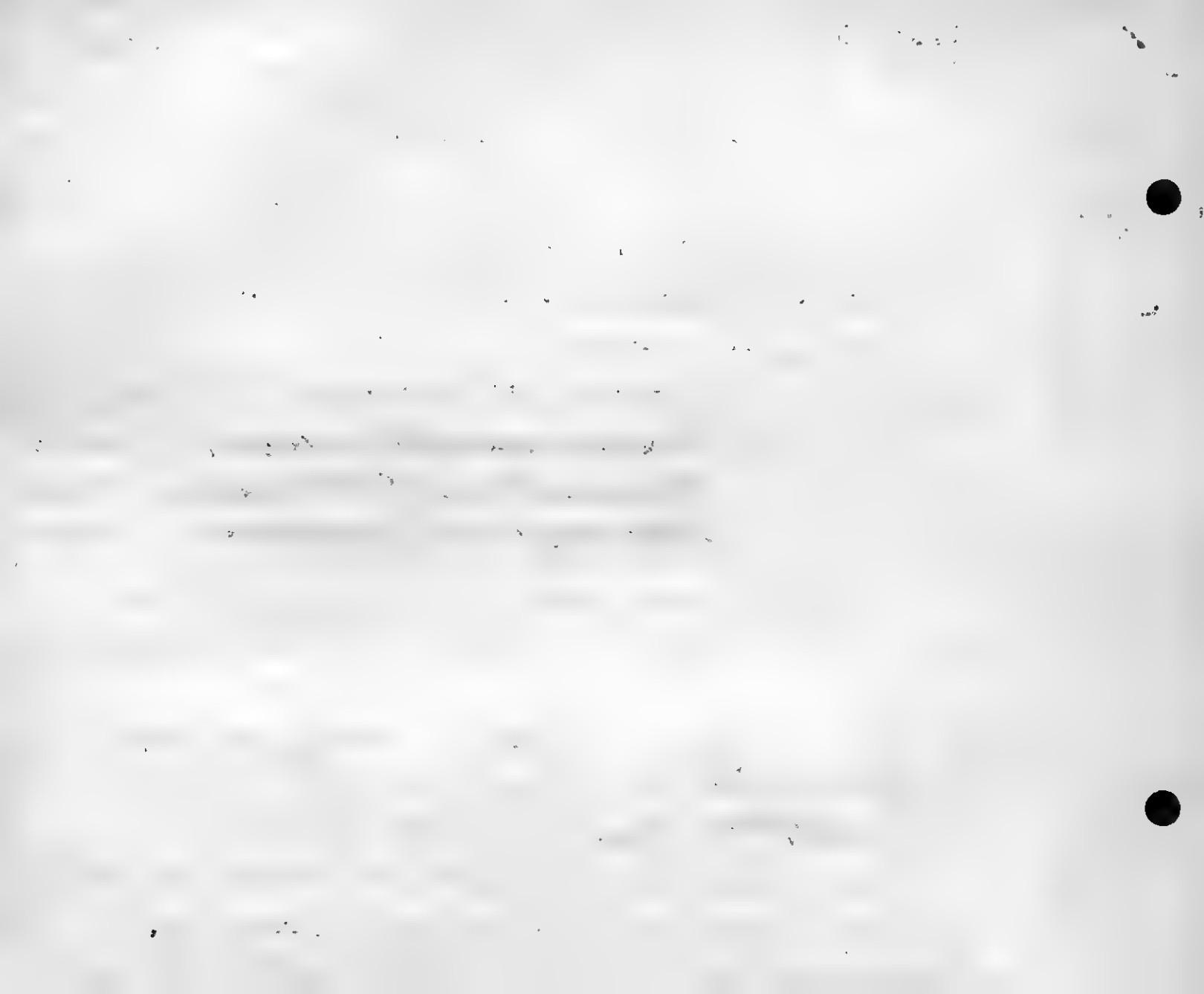
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13226

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2. Director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First HELEN	Middle A	Last MORAN	2a. DATE OF DEATH Month 9	Day 3	Year 68	2b. HOUR 10 45 M	
3. SEX female		4 RACE caucasian	5. DATE OF BIRTH 6-19-1878			6. AGE (In years last birthday) 90		F UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9912 Belhaven Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housekeeper			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13c. CITY OR TOWN Montgomery	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 9912 Belhaven Road					
14. FATHER'S NAME First John		Middle J.	Last Heffron	15. MOTHER'S MAIDEN NAME First Mary		Middle 	Last Lyon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 015-09-9706		17. INFORMANT John V. Moran, Son, same as item #11		Address			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Cerebro vascular accident</i>								<i>14 hrs</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost.</i>		<i>Deferential Cerebral Arteriosclerosis</i>								<i>6 yrs</i>
(b)		<i>Generalized Arterosclerosis</i>								<i>10 yrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. 10 Month Sept Day 3 Year 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from Sept 3 , 1968, to Sept 3 , 1968, that (I) (we) last saw the deceased alive on Sept 3 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <i>Ronald Barr, Jr. Jr.</i>		DEGREE ATTENDING PHYS.	22c. DATE SIGNED	<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.	<input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) Ronald Barr		22e. ADDRESS 10401 Old Georgetown Rd., Bethesda, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE 9-6-1968	23c. NAME OF CEMETERY OR CREMATORIAL Saint John's Cemetery			23d. LOCATION (City or Town) Hopkinton, Mass.		(County)	(State)	
24. FUNERAL DIRECTOR Joseph Lawler's Sons, Inc., 5130 Wisconsin Ave N.W., Wash., D.C., 20016		ADDRESS				25a. REC'D BY REGISTRAR DATE SEP 9 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

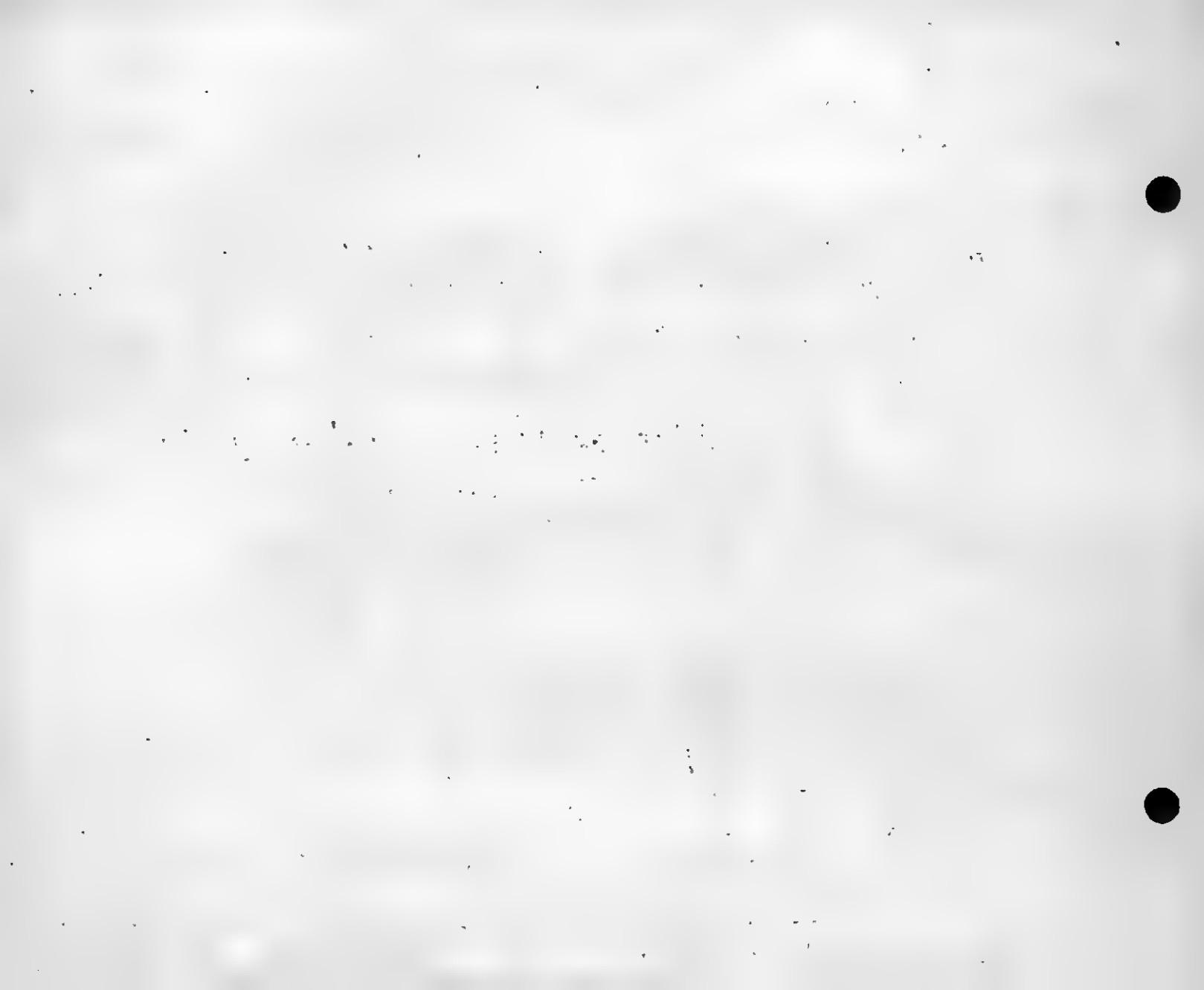
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13215

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13222

1. DECEASED NAME (Type or print)			First	Middle	Last	2d. DATE OF DEATH	2d. HOUR		
ARJA			NONE	MORGAN		9 Month	1 Day	68 year	6 1/2 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 24 HRS.	
MALE		WHITE		5/27/86		82 yrs.		MONTHS	IF UNDER 24 HRS.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Pennsylvania		USA				MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if not red)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		WASHINGTON SAN., + Hosp., Retired - Govt worker							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
DC		WASH.		WASHINGTON		YES <input checked="" type="checkbox"/>		5415 Connecticut Ave., N.W.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
WILLIAM PENN				MORGAN			RUTH		MAZY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		320-44-0561		HOSPITAL RECORDS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism in Pulmonary edema</u> 450X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute pulmonary embolism</u> 1 hr. (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 465X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/11</u> , 19 <u>68</u> , to <u>9/1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Benne G. Bendler		ATTENDING DEGREE PHYS		<input type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 9/1/68	
22d. PHYSICIAN'S NAME (Type) Benne G. Bendler		22e. ADDRESS 10820 Georgia Ave., Wheaton, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-5-1968		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION (City or Town) Bladensburg, Prince Georges		(County) (State) Md.	
24. FUNERAL DIRECTOR Joseph Lawler's Sons, Inc., 3130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS 3130 Wisc. Ave.		25a. RECD BY REGISTRAR DATE SEP 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13216

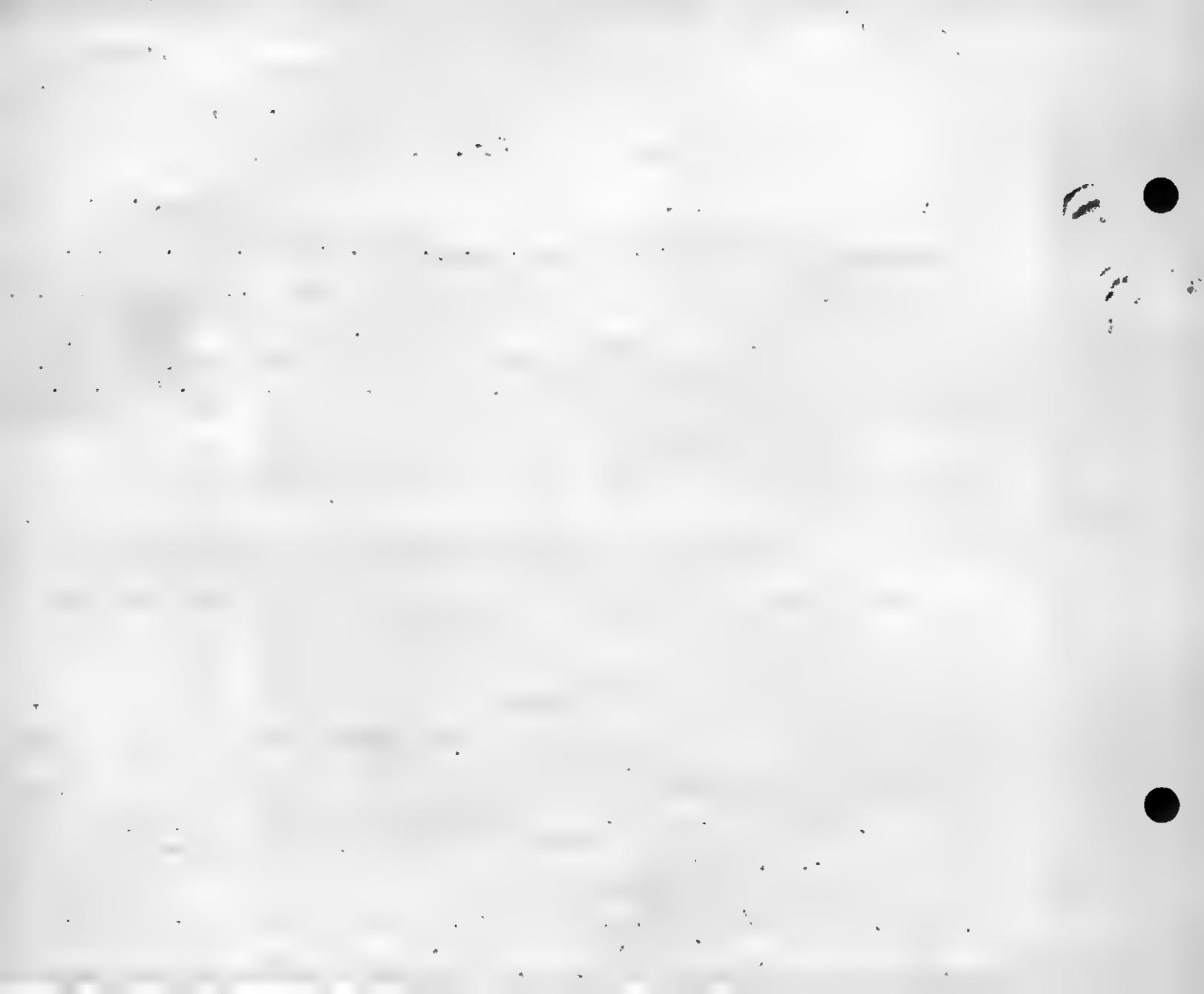
13228

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First CHARLES	Middle KROTH	Last MOSER	2a. DATE OF DEATH Month Sept. 23, 1968 Year	2b. HOUR 3:00 A.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH Aug. 27, 1877		6. AGE (In years last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Potomac	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nur. Hs., Ret. Govt. & C. Hsp.		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Govt. & C. Hsp.		12b. KIND OF BUSINESS OR INDUSTRY U.S.
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.	13b. CITY OR TOWN *****	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3623 Fessenden St. N.W.	
14. FATHER'S NAME John	First J.	Middle Moser	15. MOTHER'S MAIDEN NAME Sarah	Middle Scherer	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 579-44-3474	17. INFORMANT Mrs. Xenia E. Moser, N.W. Wash. D.C.	5623 Address Fessenden St. Wash. D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Generalized arterosclerosis</i> 440.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerosis</i> (b) <i>Bronchitis & septicemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 450.0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>7/9</u> , 1968, to <u>9/23</u> , 1968, that (I) (we) last saw the deceased alive on <u>9-18 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W. T. Joyce</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 9-23-68
22d. PHYSICIAN'S NAME (Type) W. T. JOYCE		22e. ADDRESS 4977 Battery Lane Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 9/24/68	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	23d. LOCATION (City or Town) Suitland, Md.	(County) Pr. Geo.	(State) Md.
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.	7557 ADDRESS Wisconsin Ave.	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE SEP 27 1968 Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13217

13229

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First JANE	Middle R	Last MYER	2a. DATE OF DEATH 9 Month 12 Day 68 Year	2b. HOUR 235A M
3 SEX female	4 RACE Caucasian	5 DATE OF BIRTH 6-10-1883	6. AGE (in years last birthday) 85 YRS	IF UNDER YEAR MONTHS DAYS HOURS M	
7a. BIRTHPLACE (State or foreign country) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda-Silver Spring Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE D. C.	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2737 Devonshire Place N.W.		
14. FATHER'S NAME John	First H.	Middle Rendleman	15. MOTHER'S MAIDEN NAME Cynthia	Middle Dellinger	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO	17. INFORMANT Mrs. Robert M. Burton, Sister, same as #13	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>433.9</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 day.</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis</i>			<i>5 yrs.</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>33.2 X</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1968</i> , to <i>9-12, 1968</i> , that (I) (we) last saw the deceased alive on <i>9-8 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Sanford J. Randall, MD</i>		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>9-12-68</i>
22d. PHYSICIAN'S NAME (Type) S. J. RANDALL, MD		22e. ADDRESS 3001 VEAZEE TERR. N.W.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-12-1968	23c. NAME OF CEMETERY OR CREMATORIAL Hollybrook Cemetery	23d. LOCATION (City or Town) Lincolnton, North Carolina	(County)	(State)
24. FUNERAL DIRECTOR Joseph Taylor's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS	25a. REC'D BY REGISTRAR Date SEP 16 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13218

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13230

1. DECEASED NAME (Type or Print)		First <i>Helen</i>	Middle <i>F. Nagelberg</i>	Last	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	Month Sept.	Day 19	Year 1968	2b. HOUR 6 P.M.					
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>12/07/28</i>	6. AGE (in years last birthday) <i>39</i>	F. YOUNGER 1 YEAR MONTHS <i>0</i>	E. YOUNGER 24 HRS DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>	2c. DATE PRONOUNCED DEAD Month Sept.	Day 19	Year 1968	2d. HOUR 4 P.M.			
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery.</i>		10. CITY OR TOWN OF DEATH <i>Bethesda</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Elizabeths Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Secretary</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt</i>
13a. LSLAL RESIDENCE (Where deceased lived, if not in town of residence before admission) STATE <i>M.D.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>8508-16th St.</i>	13f. ZIP CODE <i>20037</i>							
14. FATHER'S NAME First <i>Louis</i>		Middle <i>Friedman</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Stella</i>		Middle <i>?</i>	Last <i>?</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> NO		16b. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>J.S. Garlick Chapel</i>		98-60 ADDRESS <i>Queens Blvd Forest Hills, N.Y.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction, acute</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Coronary arteriosclerosis</i>												years <i>years</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>420</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>John G. Ball, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>Sept. 20, 1968</i>				
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-22-1968</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Beth Moses Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Farmingdale, L.I., N.Y.</i>								
24. FUNERAL DIRECTOR <i>Goldberg Funeral Home 4217n9th St., N.W.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

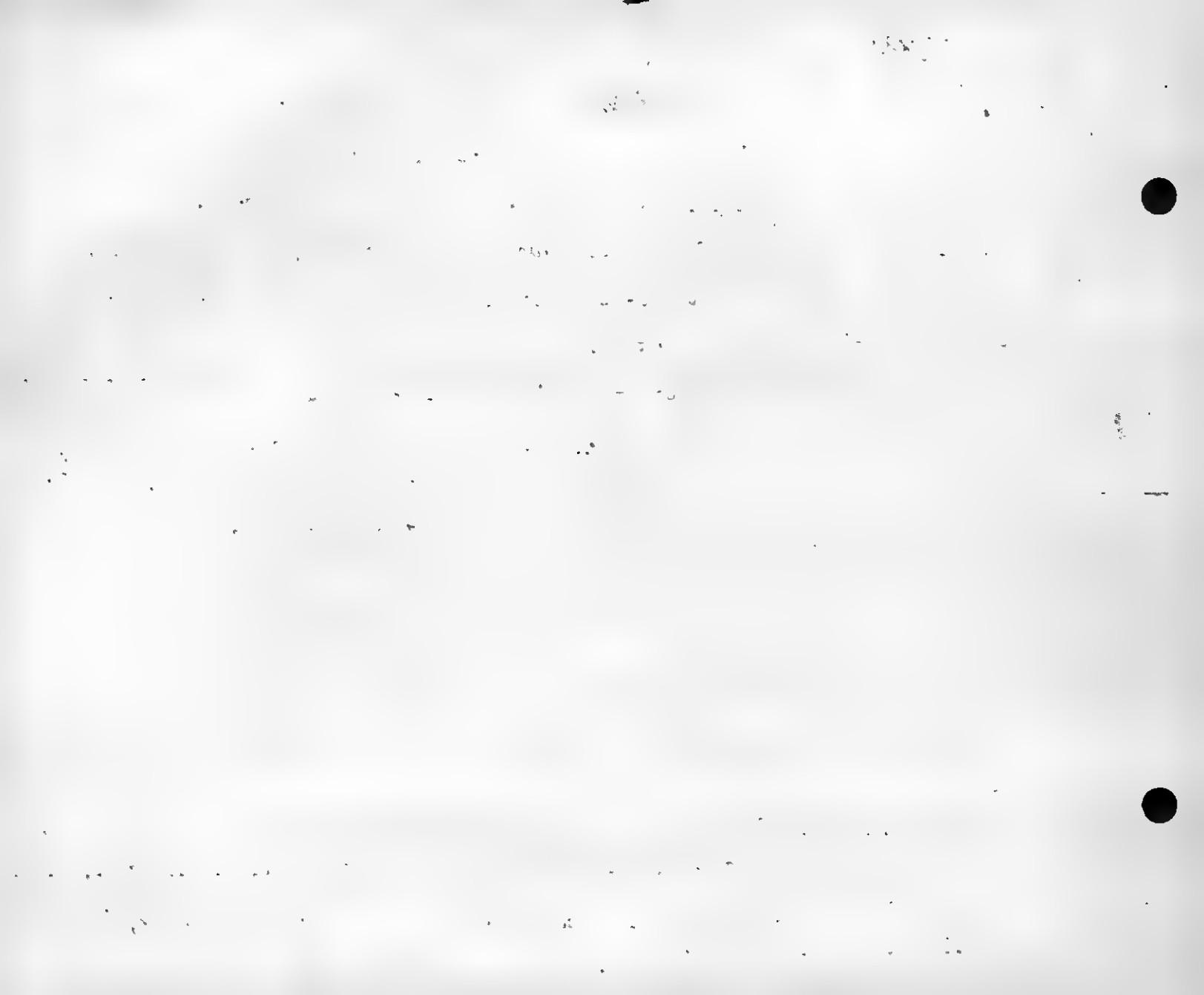
13231

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbon paper pages 1 and 2 from the back of this certificate, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper pages 1 and 2 from the front of this certificate, page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Annie</i>	Middle <i>[scribble]</i>	Last <i>O'Brien</i>	2a. DATE OF DEATH Month Day Year <i>Sept 14 1968</i>	2b. HOUR <i>3:30 AM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>April 16, 1879</i>	6. AGE (In years last birthday) <i>89 yrs.</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>	Md.	
10. CITY OR TOWN OF DEATH <i>Sil. Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>7719 Eastern Avenue</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Sil. Spr.</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>7719 Eastern Avenue</i>	
14. FATHER'S NAME First <i>John</i>	Middle <i>Marshall</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Mattie</i>	Brock		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. <i>718-14-2685</i>	17. INFORMANT <i>Bernice E. Stansbury</i>	Address <i>Sil. Spr., Md. 20882</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumosine Heart Failure</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <i>Arteriosclerotic Cardiovascular Disease - many years</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arteriosclerosis</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Anemia - mod. Severe</i> <i>4331</i>					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>..</i>		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) <i>OFFICE BUILDING, ETC.</i>	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>March</i> , 1968, to <i>Sept 14</i> , 1968, that (I) (we) last saw the deceased alive on <i>Sept 14</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Benjamin Isaacson, M.D.</i>		DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Sept. 14-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Benjamin Isaacson, M.D.</i>		22e. ADDRESS <i>7733 Alaska Avenue, N. W., Wash., D. C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>9-18-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lincoln Cemetery</i>		23d. LOCATION (City or Town) <i>Princ Georges, Maryland</i>	(County) (State)
24. FUNERAL DIRECTOR <i>John G. Carter</i>	ADDRESS <i>Kerner E. Pumpingou, P.O. Box 8034 Cr. Ave. S.S., Md.</i>	25a. REC'D BY REGISTRAR <i>SEP 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13232

13220

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Julian</i>	Middle	Last <i>Olmsted</i>	2a. DATE OF DEATH Month <i>9</i>	Day <i>20</i>	Year <i>68</i>	2b. HOUR <i>6 p.m.</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>4/22/14</i>	6. AGE (in years last birthday) <i>34 yrs</i>	F UNDER 1 YEAR MONTHS <i>3</i>	DAYS <i>18</i>	HOURS <i>6</i>	MIN. <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Calif. USA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery Co. Md.</i>					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>10140 Cross Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>None</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>	13c. CITY OR TOWN <i>Gaithersburg</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>9701 Fields Rd #701</i>					
14. FATHER'S NAME First <i>Frederick</i>	Middle <i>Olmsted</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Florence Du Bois</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>217-44-0301</i>	17. INFORMANT <i>9701 Fields Rd. Adams Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Small bowel obstruction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Encrusted lops of small bowel</i> (b) <i>Intestinal obstruction of large bowel</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Intestinal obstruction of large bowel</i>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>9/19 1968</i> , to <i>9/20 1968</i> , that (I) we last saw the deceased alive on <i>9/20 1968</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.								
22b. SIGNATURE <i>Robert C. Daddario</i>		MD DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>9/21 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>ROBERT C. DADDARIO</i>		22e. ADDRESS <i>8413 CEDAR LANE BETHESDA MD</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>9-23-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>	23d. LOCATION (City or Town) <i>Suitland, Pr. Geo. Md.</i>	(County)	(State)		
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ABOVE ADDRESS	25a. REC'D. BY REGISTRAR <i>SEP 27 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13221

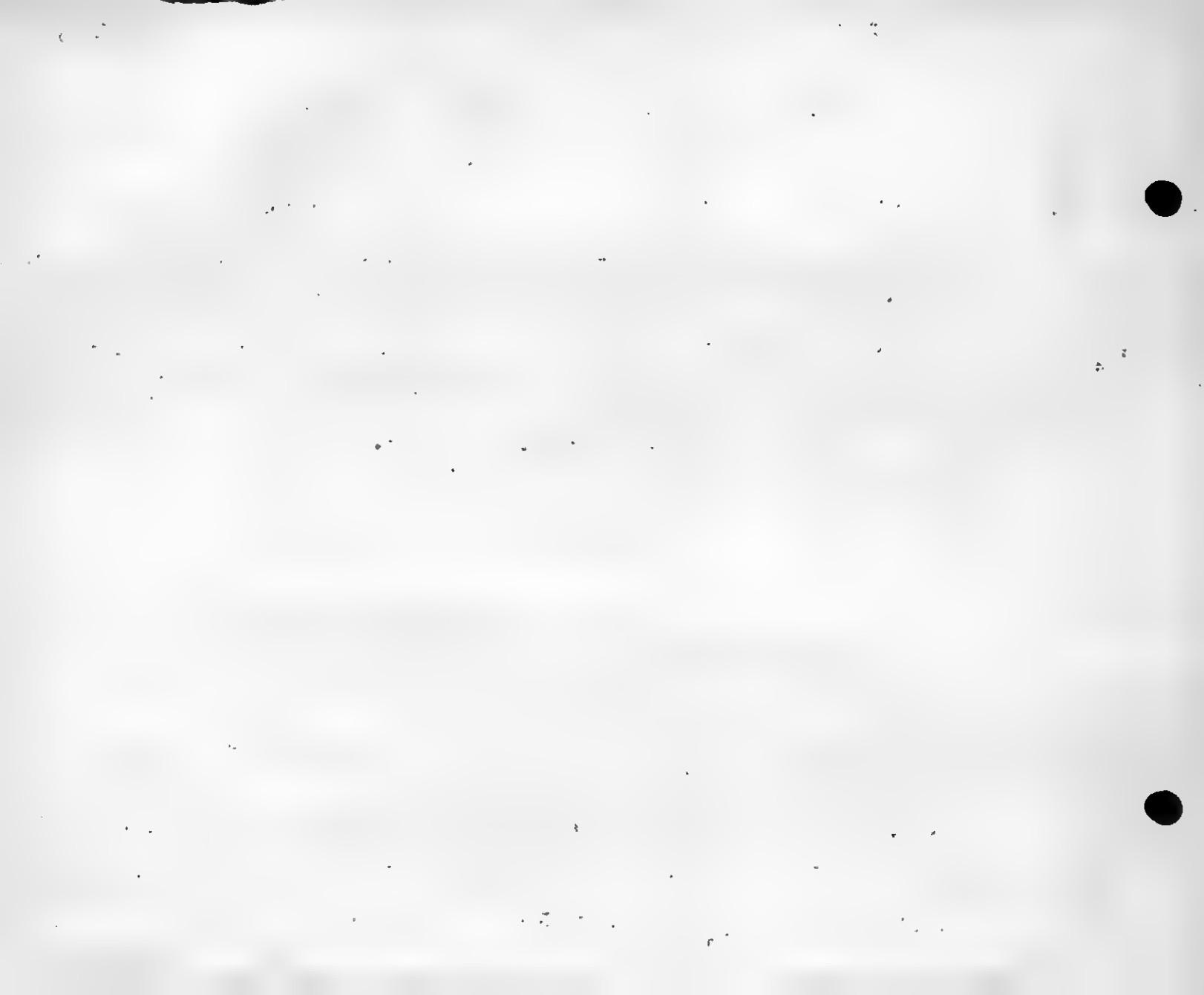
13233

Item #23b Film GL05 10/2/68 km CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)		First Collis	Middle A.	Lost	2a. DATE OF DEATH Month Setpember Day 16 Year 1968	2b. HOUR 1115 p		
3 SEX Female		4 RACE Caucasian	S. DATE OF BIRTH Jan. 16, 1920	6. AGE (In years last birthday) 48 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Educational secretary			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Falls Church	13c. CITY OR TOWN Falls Church	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2642 Mann Court	12b. KIND OF BUSINESS OR INDUSTRY Fairfax Co.		
14. FATHER'S NAME Hugh First Arthur Middle Allen Last		15. MOTHER'S MAIDEN NAME Collis First Huntington Middle Lackey Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, if unknown No		16b. SOCIAL SECURITY NO 577 22 1059	17. INFORMANT Falls Church	Address Va. Frank T. Onachila, 2642 Mann Court				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Leiomyosarcoma uterus, status post hysterectomy								
DUE TO, OR AS A CONSEQUENCE OF with metastases								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State	
22a. I certify that (s) (this hospital) attended the deceased from Aug. 21, 1968, to Sept. 18, 1968, that (s) (we) last saw the deceased alive on Sept. 18, 1968, and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) did (s) (did not) view the body after death.								
22b. SIGNATURE John D. Bell, M. D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED Sept. 19, 1968			
22d. PHYSICIAN'S NAME (Type) John D. Bell, M. D.		22e. ADDRESS Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 25, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery			23d. LOCATION (City or Town) Arlington	(County) Va.	(State)
24. FUNERAL DIRECTOR Covington & Martin Funeral Home, 6161 Leesburg Pike Falls Church		ADDRESS James Deaf	25a. REC'D BY REGISTRAR DATE SEP 25 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13234

CERTIFICATE OF DEATH

13222



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Catherine	Middle N.	Last PABST	2a. DATE OF DEATH September 4, 1968	Month Year	2b. HOUR 4:30 PM			
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH October 31, 1905		6. AGE (In years last birthday) 62	16. JUNIOR 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) Washington	7b. CITIZEN OF WHAT COUNTRY? U. S.	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital (give street address)) Naval Hospital, Bethesda			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 14225 Hi-wood Drive					
14. FATHER'S NAME Charles	First M.	Middle NICHOLSON	15. MOTHER'S MAIDEN NAME Ethel	First A.	Middle JONES	Address Md.			
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. N/A	17. INFORMANT Avery A. PABST, 14225 Hi-wood Dr., Rockville,		metastases APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cystadenocarcinoma of ovaries with abdominal metastases 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 175									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory OFFICE, BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State		
22a I certify that (I) (this hospital) attended the deceased from August 14, 1968, to September 4, 1968, that (we) lost saw the deceased alive on September 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE W. M. MURPHY, M.D.	DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED September 4, 1968					
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Naval Hospital, Bethesda, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 999-68	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Virginia						
24. FUNERAL DIRECTOR Robert A. Humphrey, Bethesda, Md.	ADDRESS	25c. REC'D. BY REGISTRAR DATE SEP 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13235

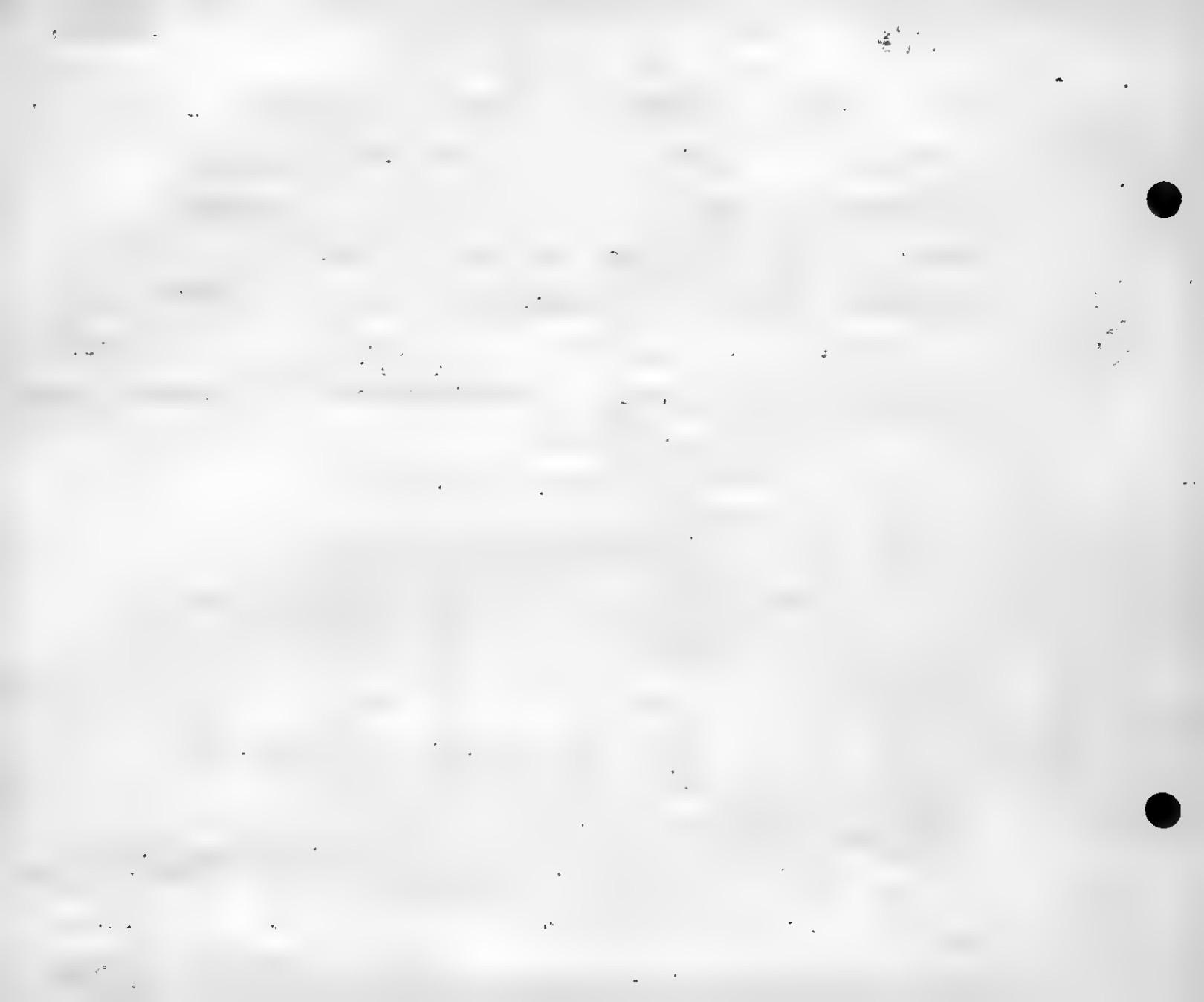
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please send 2 copies and 2 envelopes. If any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First MARK	Middle ANTHONY	Last PARKS	2a. DATE OF DEATH Month September	Day 12	Year 1968	2b. HOUR 11:00 AM
3 SEX Male	4 RACE White	5 DATE OF BIRTH 5 March 1966		6. AGE (in years last birthday) 2		YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery				
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Child		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE West Virginia	13b. COUNTY Eckman	13c. CITY OR TOWN Eckman	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/>	13e. STREET AND NUMBER (None)			
14 FATHER'S NAME First Donald	Middle T.	Last Parks	15. MOTHER'S MAIDEN NAME First Martha	Middle 	Last Mitchem		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) None	17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Hours			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock ? Septic 2105 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Gastroenteritis with Dehydration (b) DUE TO, OR AS A CONSEQUENCE OF last. Cystinosis						7 Days Life	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING Cause of Death (If either, nat'lly medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat wh le <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 11, 1968 , to Sept. 12 1968 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Sept. 12 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Joseph D. Schulman, M.D.</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED 9/12/68	
22d. PHYSICIAN'S NAME (Type) Joseph D. Schulman, M. D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. CERIAL CREMATON, REMOVAL (Specify)	23b. DATE 9-15-68	23c. NAME OF CEMETERY OR CREMATORIAL ALFRED WADE CEM.	23d. LOCATION (City or Town) ECKMAN W. VIRGINIA	(County)	(State)		
24. FUNERAL DIRECTOR WW CHAMBERS CO	ADDRESS 1400 CHAPIN ST. N.W. WASH. D.C.	25a. REC'D BY REGISTRAR DATE SEP 17 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF EST. DEATH MATED	Month	Day	Year	2b. HOUR 10 AM
<i>Augustus</i>		<i>Patrick</i>							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years at 1st birthday)	F UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	2d. HOUR 10 AM
Male	Colored	2/6/06	62 yrs.					Sept. 26	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		<i>Montgomery</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
<i>Bethesda</i>		<i>St. Luke's Hospital</i>							
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13c. CTY OR TOWN		13d. INSIDE CTY LIMITS?		13e. STREET AND NUMBER			
<i>T.C. 21</i>		<i>Washington</i>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<i>1404 - Half St. S.W.</i>			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> , No <input type="checkbox"/> , Unknown <input type="checkbox"/>)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
<i>No</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intracerebral hemorrhage</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 hr.</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>cerebral arteriosclerosis</i> <i>years</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>2518</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John E. Bell</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county)					
23a. BRIEF CREMATION, REMOVAL (Specify)		23b. DATE <i>10/2/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>HARMONY MEM Park</i>		23d. LOCATION (City or Town) <i>Lanover</i>		(County) <i>Md.</i> (State)	
24. FUNERAL DIRECTOR <i>JOHNSON & JENKINS</i>		ADDRESS <i>4800 Georgia Ave. NW</i>		25a. REC'D BY REGISTRAR <i>OCT 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
FUNERAL HOME, INC.		WASH. D.C.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FINEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. A copy of this certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

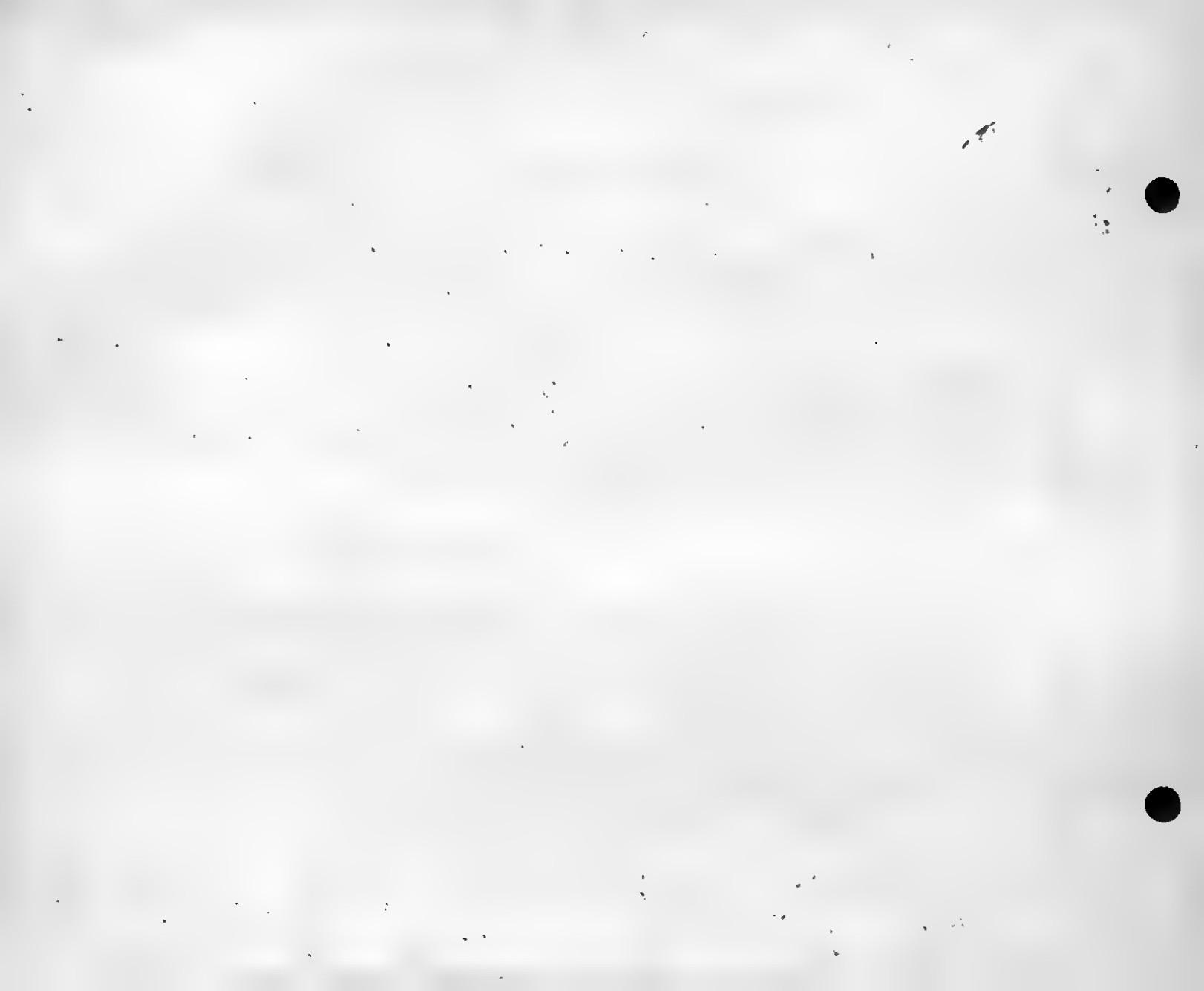
13225

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13237

1. DECEASED-NAME (Type or print)	First Laura	Middle Elizabeth	Last Patton	2a. DATE OF DEATH Month 9	Day 1	Year 1968	2b. HOUR 10:40 AM		
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH 10-30-03			6. AGE (In years last birthday) 64	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) AMERICA	7b. CITIZEN OF WHAT COUNTRY? AMERICA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 COUNTY OF DEATH MONTGOMERY						
10. CITY OR TOWN OF DEATH TAKOMA PARK	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b KND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN TAKOMA PARK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 804 MAPLEWOOD					
14. FATHER'S NAME First EMIL	Middle WITZKE	Last	15. MOTHER'S MAIDEN NAME First Nelvin	Middle HARST	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, no, or unknown	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 225-48-1577	17. INFORMANT HOSPITAL RECORDS	Address TAKOMA PARK, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4337 I had C.V.A., probably thrombosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from YEARS , 19 1968 , to 1968 , that (I) (we) last saw the deceased alive on AUG 31 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Chas H. Wolfson, M.D.		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9/11/1968				
22d. PHYSICIAN'S NAME (Type) Chas H. Wolfson		22e. ADDRESS 831 University Blvd. E. S. I. M.							
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept 4 68	23c. NAME OF CEMETERY OR CREMATORIUM Geo. Park Cemetery			23d. LOCATION (City or Town) Baltimore	County Baltimore	State MD	
24. FUNERAL DIRECTOR Arthur Walters		25. ADDRESS 254 Carroll St.			25a. REG'D BY REGISTRAR D.S.P. 4 SEP 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1322C

13238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME CHARLES HENRY PAYNE				2a. DATE OF DEATH September 24 1968	2b. HOUR 11:30 A.M.
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH 8-21-83	5. AGE (in years last birthday) 85 YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) POSTAL CLERK, RETIRED U.S. POST OFFICE	12b. KIND OF BUSINESS OR INDUSTRY GREAT OAK ROAD		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN Manor Club	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 4509 Great Oak Road	
14. FATHER'S NAME CHARLES THOMAS PAYNE	15. MOTHER'S MAIDEN NAME MARY BETTY THORP				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO	16b. SOCIAL SECURITY NO. 217-52-8408	17. INFORMANT Mrs. Janet L. Kenyon	Address Manor Club, Md. 4509 Great Oak Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Congestion Approximate Interval Between Onset and Death 1 wk Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Bronchopneumonia (c) A.S.C.V.D.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Emphysema					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) 21d. LOCATION Street or R.F.D. No. City or Town County State		
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22a. I certify that (1) (this hospital) attended the deceased from July 1968 , to 24 Sept 1968 , that (1) (we) last saw the deceased alive on 23 Sept 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death.					
22b. SIGNATURE Donald R. Lewis MD		22c. DATE SIGNED 9-24-68			
22d. PHYSICIAN'S NAME (Type) DONALD R. LEWIS, M. D.		22e. ADDRESS 700 CLOVERLY ST., SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-27-1968	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery	23d. LOCATION (City or Town) Prince Georges, Maryland	(County) Prince Georges	(State) Maryland
24. FUNERAL DIRECTOR C. Glen Carter	ADDRESS Warren E. Pumphrey, Inc. 8434 Ga Ave S.S., Md.	25a. REC'D BY REGISTRAR SEP 27 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

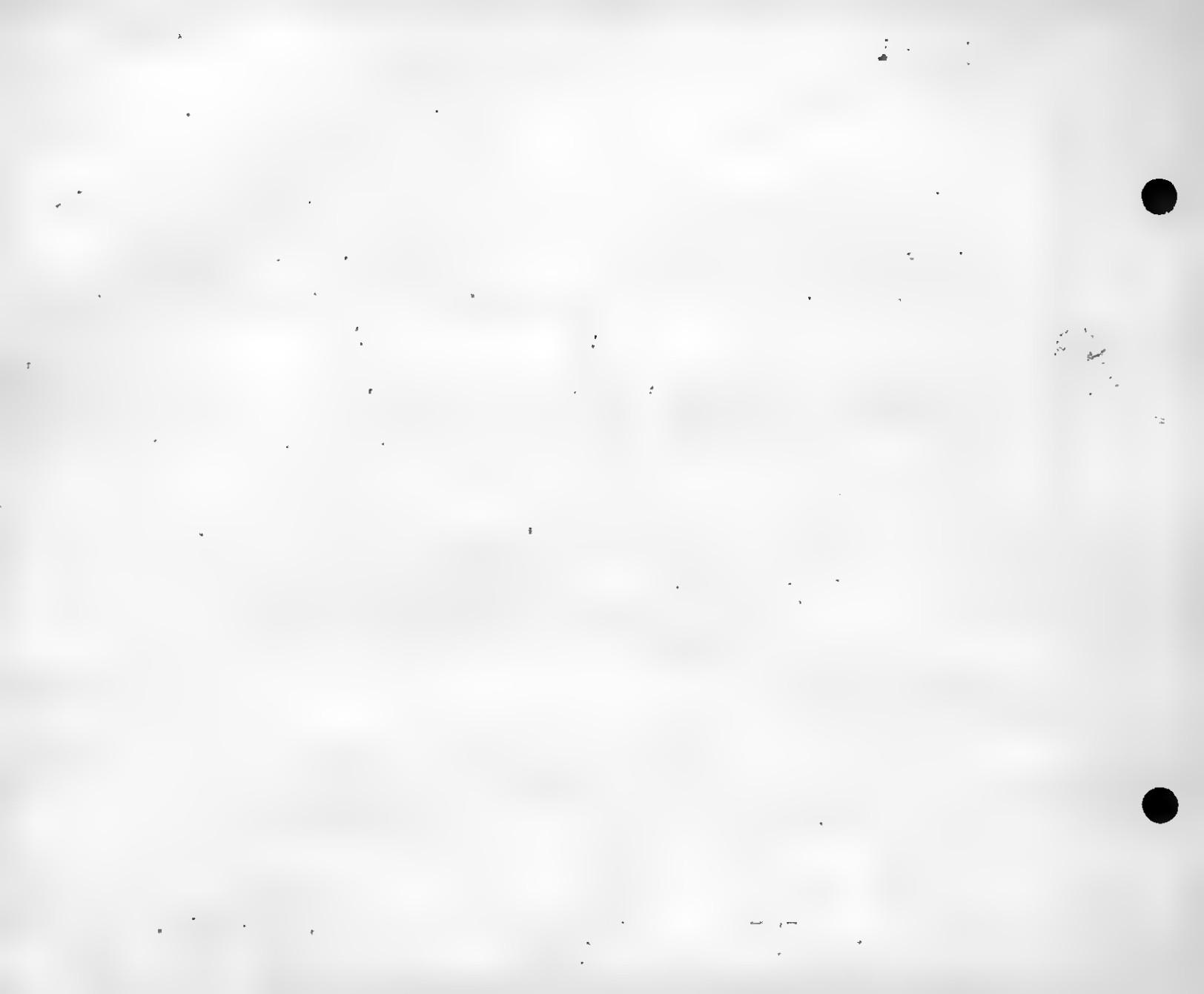
13227

13239

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First <i>Alma</i>	Middle <i>L.</i>	Last <i>Perry</i>	2a. DATE OF DEATH Month <i>9</i>	Day <i>10</i>	Year <i>68</i>	2b. HOUR 12 AM
3. SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>4-24-02</i>			6. AGE (In years last birthday) <i>66</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Tenn.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>			Md	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Sanitarium & Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>	13b. CITY OR TOWN <i>University Park</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>6607 44th Avenue</i>				
14. FATHER'S NAME First <i>Robert</i>	Middle <i>Heath</i>	15. MOTHER'S MAIDEN NAME First <i>Hillian</i>	Middle <i>Bynum</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>408-36-6845</i>	17. INFORMANT <i>Records - Washington Sanitarium & Hospital</i>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bone marrow aplasia</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year.</i>	
16a Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Plasmacytoma.</i>						DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>7-26, 1968</i> , to <i>9-10, 1968</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert E. Wilhelm, M.D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Sept 16 1968</i>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>9-14-68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>BYHALIA CEMETERY</i>			23d. LOCATION (City or Town) <i>BYHALIA, MISS.</i>	(County)	(State)
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND				ADDRESS	25a. RECD BY REGISTRAR DATE <i>SEP 16 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13240

13228

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper [] and 2 [] and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Doy	Year	2b. HOUR			
<i>FERNANDA ELISCU</i>				<i>Pfeil</i>	9	26	1968	12 05 PM			
3. SEX		4. RACE		S. DATE OF BIRTH	6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
<i>Female</i>		<i>White</i>		<i>4/24/80</i>	88 YRS						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH						
<i>ROUMANIA</i>		<i>U. S. A.</i>			<i>Montgomery</i>						
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY				
<i>Silver Spring</i>		<i>Holy Cross</i>			<i>ACTRESS</i>						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c CITY OR TOWN		13d INSIDE CITY, MTS?	13e STREET AND NUMBER						
<i>MARYLAND</i>		<i>MONTGOMERY</i>		<i>ROCKVILLE</i>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<i>11801 Danville Drive</i>					
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
		<i>SAMUEL</i>		<i>ELISCU</i>		<i>SHARAGA</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address					
		<i>545-24-5102</i>		<i>Mrs. Eugenie Bielefeldt</i>		<i>11801 Danville Drive Rockville, Maryland</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Coronary Artery Disease (Congestive failure) 5 years</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>4-1</i>											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 26, 1968</i> , to <i>Sept 26, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 26, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)		<i>BLAINE H. EIG</i>			22e. ADDRESS		<i>9701 Georgia Ave Silver Spring, Md</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town) (County) (State)				
<i>BURIAL</i>		<i>SEPT. 30, 1968</i>		<i>Mount Pleasant Cemetery</i>			<i>Hawthorne, New York</i>				
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<i>Donald M. Stein</i>		<i>232 Carroll</i>			<i>AT SEP 30 1968</i>		<i>Charles Judge</i>				
Hebrew Memorial Funeral Home		St. N.W. Wash. D.C.									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

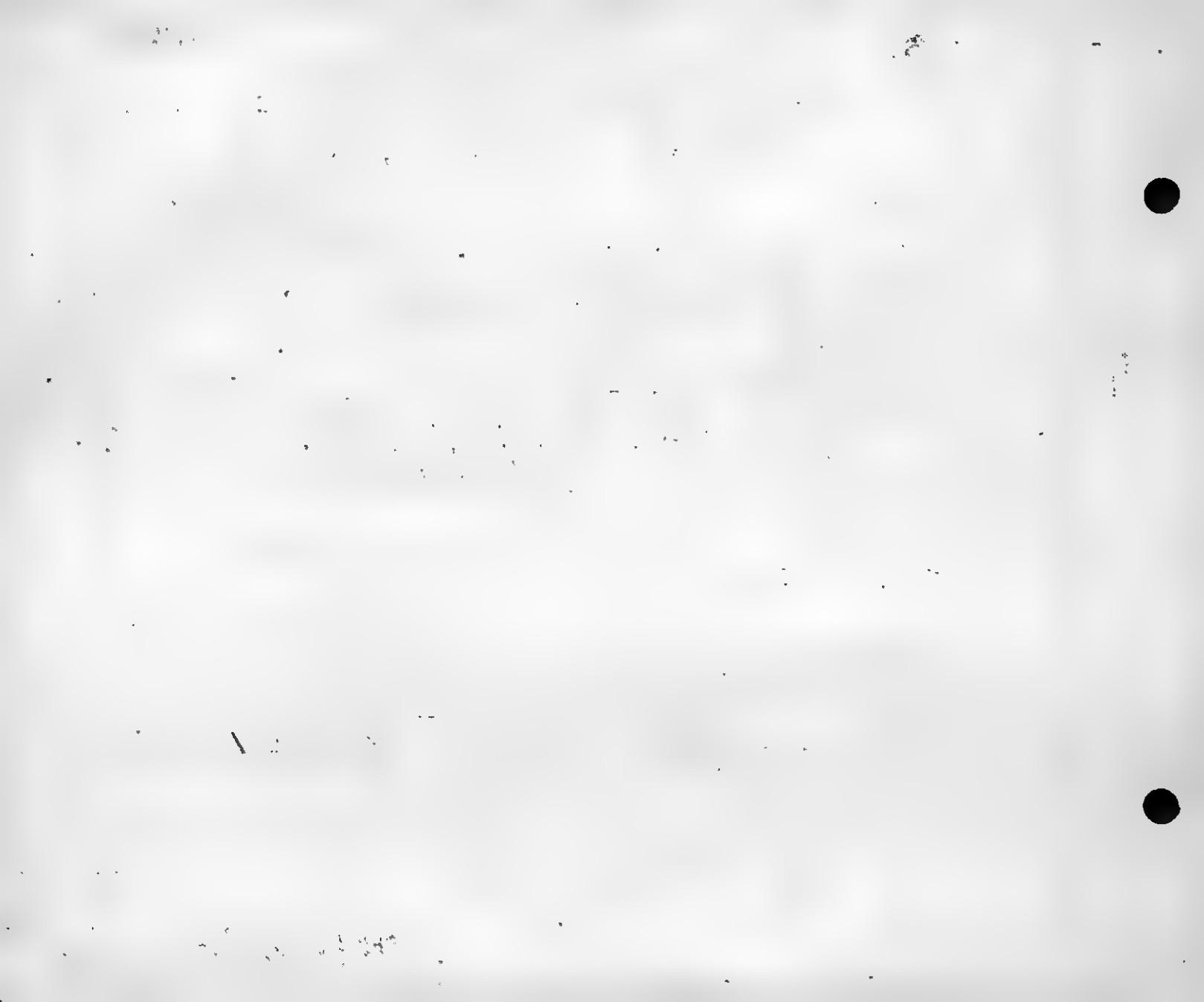
CERTIFICATE OF DEATH

13229

13241

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

1. DECEASED-NAME (Type or print)			First George	Middle McCall	Last Pickrell	2a. DATE OF DEATH Month Sept	Day 10	Year 1968	2b. HOUR M		
3. SEX Male		4. RACE White	5. DATE OF BIRTH January 3, 1903			6. AGE (in years less birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3404 Chiswick Ct.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Real Estate Broker Self-Employed			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 3404 Chiswick Court							
14. FATHER'S NAME First George		Middle Pickrell	Last	15. MOTHER'S MAIDEN NAME First Elizabeth		Middle McGlensey	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) X-X-X-X		17. INFORMANT 225-09-07854 Sarah P Pickrell		Address 3404 Chiswick Ct., Silver Spring, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Monr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause last 4000 (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (I) (This hospital) attended the deceased from JAN 30, 1962 , to Sept 10, 1968 , that (I) (we) last saw the deceased alive on Sept 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Warren D. Brill, M.D.		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED Sept 11, 1968					
22d. PHYSICIAN'S NAME (Type) Warren D. Brill, M. D.		22e. ADDRESS 2001 - 15th St., N.W., Washington, D.C.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/12/68	23c. NAME OF CEMETERY OR CREMATORIAL Hollywood Cemetery			23d. LOCATION (City or Town) Richmond,		(County) Virginia			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS 7557 Wisconsin Ave Bethesda, Maryland			25a. REC'D BY REGISTRAR SEP 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

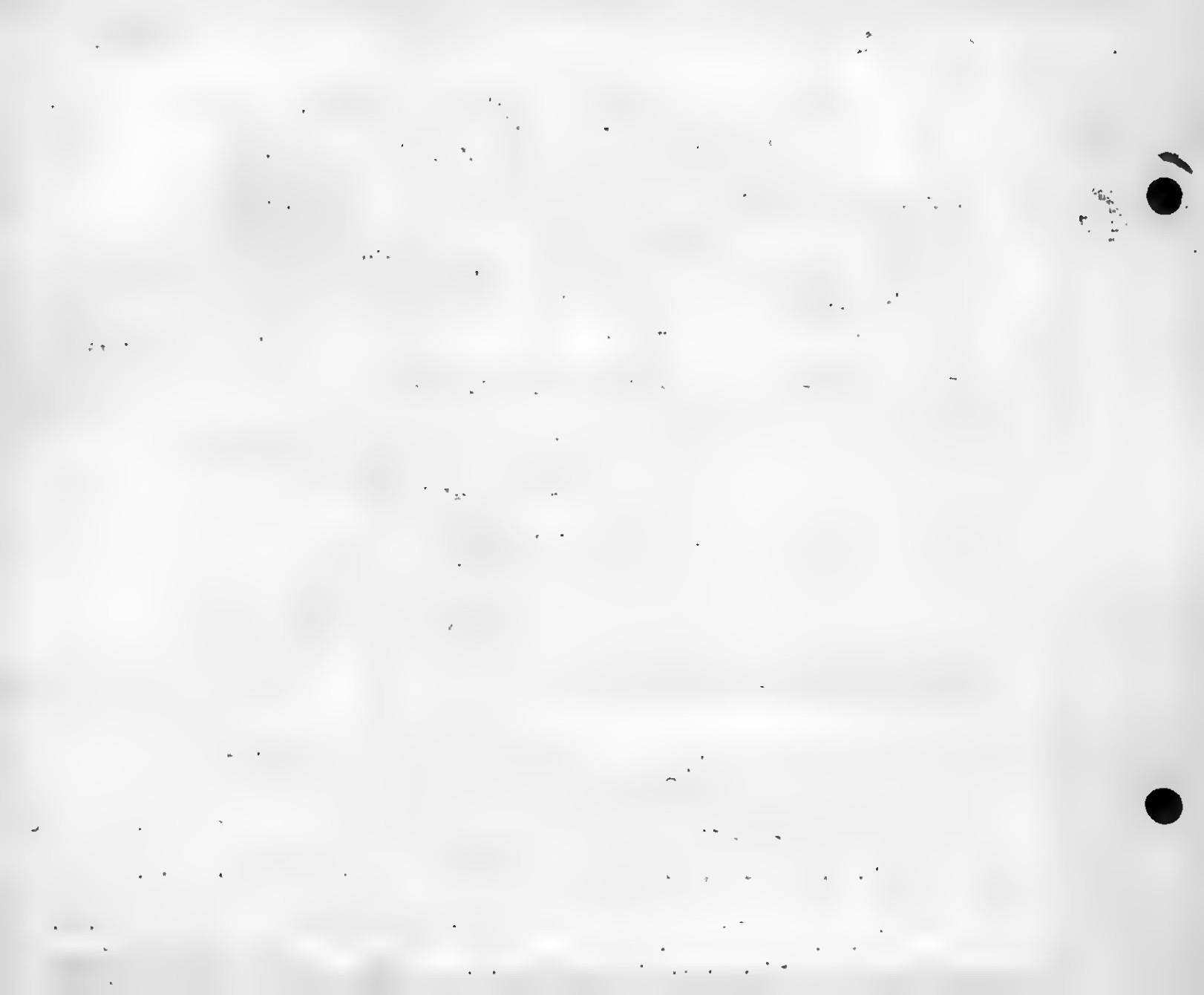
13242

13230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First William	Middle James	Lost PINTER	2a. DATE OF DEATH Month Sept.	Year 12	2b. HOUR 68 2:00A					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Nov. 25, 1948		6. AGE (In years last birthday) 19		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	MIN	
7a. BIRTHPLACE (State or foreign country) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Marine Corps		12b. KIND OF BUSINESS OR INDUSTRY N/A						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Virginia		13c. CITY OR TOWN Gary		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER						
14. FATHER'S NAME First Claude		Middle Pinter	Lost	15. MOTHER'S MAIDEN NAME First Edina		Middle Mae	Lost Blevins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no unknown Yes		16b. SOCIAL SECURITY NO. 1966-68		17. INFORMANT Hospital Records		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia and Congestive Heart Failure												
DUE TO, OR AS A CONSEQUENCE OF (b) Fracture Left Femur Supracondyle and												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) Shrapnel Wounds of Abdomen												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 1100m Apr 14 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Enemy action								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. Near Phu Bai		City or Town		County	State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 6, 1968 , to Sept. 12, 1968 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Sept. 12, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death.											Viet Nam	
22b. SIGNATURE H. E. Ashworth		MD. DEGREE		ATTENDING PHYS	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input checked="" type="checkbox"/>	22c. DATE SIGNED Sept. 12, 1968		
22d. PHYSICIAN'S NAME (Type) H. E. ASHWORTH, LCDR MC USN		22e. ADDRESS Naval Hospital, Bethesda, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-17-68		23c. NAME OF CEMETERY OR CREMATORIUM Roderfield Cemetery		23d. LOCATION (City or Town) Roderfield		(County)		(State) W. Va.		
24. FUNERAL DIRECTOR W. W. Chambers Co.		ADDRESS 1400 Chapin Street, N.W., Washington, D.C.		25a. REC'D BY REGISTRAR SEP 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13243

13232

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR 11:30 AM
<i>Thomas Levi Prather, Sr.</i>					9-3-68	
3. SEX	4 RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male	N	8-15-11		57 yrs.		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH	10. CITY OR TOWN OF DEATH	
Md.	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery	Laytonsville	
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Potomac Valley		Janitor				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY, TOWNSHIP, ETC. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER	21401 Burnham Rd, Gaithersburg	
Md.	Montgomery	Gaithersburg		21401	Burnham Rd.	
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle
Darius			Prather	Sarah		Copeland
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	7. INFORMANT	Address	17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes, no or unknown NO	214-18-8565	Justine Prather, Wife	21401 Gaithersburg	1 DAY		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>(Cerebral) Thrombosis, Repeated</i>						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral and Generalized Arteriosclerosis</i> 1 yr.						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Esophageal Varices, Hepatic Atrophy, Prostactic Hypertrophy</i>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat wh <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from Oct. 19, 1957 to 9-3-68, that (I) (we) last saw the deceased alive on 9-3-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Clive F. Jackson, MD</i>		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 9-4-68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>202 Martin L., Rockville, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4-7-68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Brooke-Grove Cem Laytonsville Montg. Md.</i>	23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Robert L. Snowden Rockville, Md.</i>	ADDRESS	25a. RECEIVED BY REGISTRAR DATE SEP 6 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be certified within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

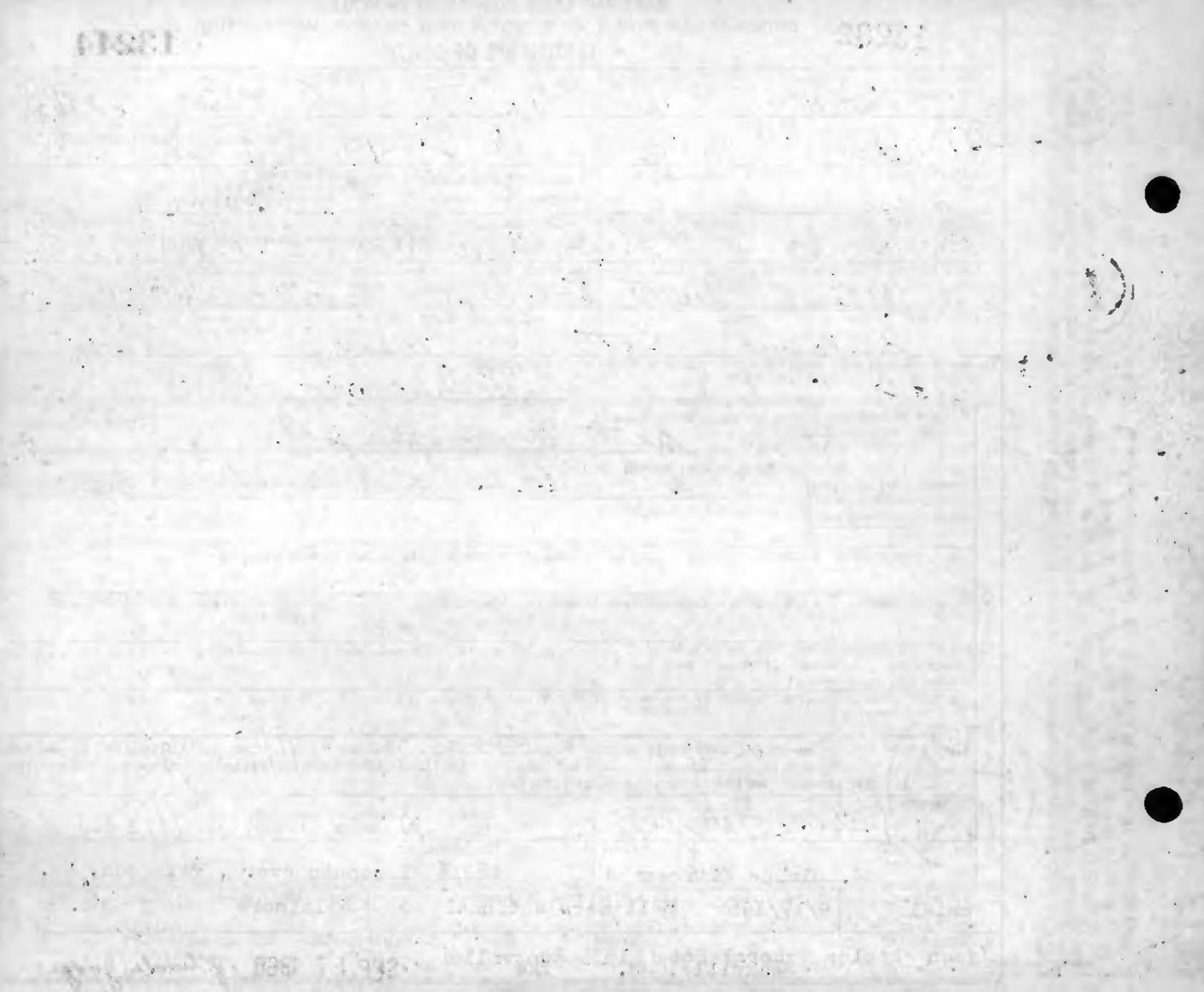
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that Page 4 may be retained by the hospital or attending physician.

GENERAL DIRECTOR: After this certificate has been signed by the

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First James	Middle W.	Last Peatt	2a. DATE OF DEATH Month 13 Day Year 9 13 68	2b. HOUR 1240 M		
3. SEX Male		4. RACE White	5. DATE OF BIRTH 6/6/1917		6. AGE (In years last birthday) 57	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HOURS HOURS MIN.		
7. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? A.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If non-in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Chemist - N.H.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. INSIDE CITY LIMITS? YES		13e. STREET AND NUMBER 13703 Frankfort Ave			
14. FATHER'S NAME First Gustavus Middle Fratt Last			15. MOTHER'S MAIDEN NAME First Mary Middle			Last Betty.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes -			16b. SOCIAL SECURITY NO.			17. INFORMANT Wife-Eleanor - Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION 4201		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from October 1967 , to 9/13 1968 , that (I) (we) last saw the deceased alive on 9/6 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED 9/13/68.	
22b. SIGNATURE J. Blaine Fitzgerald		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) J. Blaine Fitzgerald		22e. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/17/1968		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City or Town) Baltimore		(County)	(State) Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rockville Pike		25a. REC'D BY REGISTRAR Charles J. Jones		25b. REGISTRAR'S SIGNATURE Charles J. Jones			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13233

13245

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10. FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Leroy	Middle	Lost Purdum	20. DATE OF DEATH Month Day Year Sept. 10, 1968	2b. HOUR 2P.M.
3. SEX Male	4. RACE White	S. DATE OF BIRTH May 22, 1899	6. AGE (In years lost/birthday) 69 yrs.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nursing	Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13c. CITY OR TOWN Montgomery	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RFD # 1, Gaithersburg		
14. FATHER'S NAME First Luther M. Purdum	Middle	Lost	15. MOTHER'S MAIDEN NAME Sarah	Middle Lost L. Murdoch	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-36-6677	17. INFORMANT Arthur B. Purdum, Gaithersburg, Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung with metastases 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 163X (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years?					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Cardiovascular Disease with previous Cerebral Thrombosis					
19a. MEDICAL CERTIFICATION DATE OF OPERATION May 21, 1968	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Left Lobectomy with attempted removal of metastatic areas pleura & diaphragm.	20a. AUTOPSY? NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) No injury			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State	
22a. I certify that (I) (this hospital) attended the deceased from July 2, 1966, to September, 1910. I (we) last saw the deceased alive on September 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. McKendree Boyer, M.D.	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED September 10, 1968	
22d. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D.	22e. ADDRESS 9701 Church Street Damascus, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 12, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Upper Seneca Baptist	23d. LOCATION (City or Town) Cedar Grove, Md.	(County) (State)	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.	ADDRESS	25a. RECD BY REGISTRAR DAT SEP 13 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

23561

